Focusing on obesity through a health equity lens

A collection of innovative approaches and promising practices by health promotion bodies in Europe to counteract obesity and improve health equity
EuroHealthNet is a European Network that consists of 36 national and regional Public Health and Health Promotion Agencies in Europe. The network brings together national health promotion representatives to discuss EU policies and initiatives that are relevant for population health. The overall aim of EuroHealthNet is to reduce health inequalities between and within European countries.

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Introduction

This report has been compiled by EuroHealthNet with the aim of producing an accessible source of ideas and inspiration for practitioners and policy makers about counteracting obesity and improving health equity. The work is funded under the Equity Channel special project [1] of EuroHealthNet, which is part of the International Collaboration on Social Determinants of Health, initiated by the Department of Health for England.

The report:
- describes innovative approaches and promising practices to reduce obesity by health promoting bodies in Europe at local, regional, national and European level;
- is an identification of work where the initiatives address different socio-economic groups with a specific focus on lower socio-economic communities, and therefore contribute to reducing health inequalities; and
- is an update of the 2006 summary of action collated by EuroHealthNet [2].

Report Content

Lifestyle choices regarding nutrition and physical activity are the most direct determinants of overweight and obesity. However, while predominantly concerned with nutrition and physical activity initiatives, the remit of the report was to include any possibly relevant interventions. This information was collected from:
- EuroHealthNet member and partner organisations;
- DETERMINE [3] member and partner organisation;
- statutory bodies at European, national, regional and local levels in Europe; and
- other sources with their clear permission (e.g. academic, private or nongovernmental organisations).

A framework document, including specific questions related to counteracting obesity among vulnerable groups and details of the project’s methodology, was sent to all European countries. In total 71 relevant descriptions of innovative approaches, running in twenty different countries (figure 1), were submitted. The practices described are implemented at either European, national, regional or local level. Most interventions found are community based approaches that are active at the regional or local level.

The report includes interventions which are ‘innovative’. This is a broad concept that can be defined as a new or different approach to addressing an issue [4]. This could for instance include involving new partnerships or finding new ways to target and reach specific groups. However, it is important to note that the aim of this report was not to categorise the projects, to say whether one intervention is more innovative than another, nor to find new strategies that could be implemented all across Europe. Innovation depends on the context it operates in, it is relative to the country where it is implemented and it will constantly be changing. The goal of the report was therefore to highlight new, recent approaches that have the potential to work and to be effective, to raise awareness - especially because many of the projects are implemented at local level-, and to provide others with new ideas and inspiration to tackle obesity and improve health equity.

Figure 1 Austria, Belgium, Bulgaria, Czech Republic, Denmark, England, Finland, France, Germany, Greece, Ireland, the Netherlands, Norway, Portugal, Romania, Scotland, Slovak Republic, Slovenia, Spain, and Sweden.
Report Layout

After an introduction to the obesity pandemic, a description of health inequalities and the importance of targeting vulnerable groups, the content of the report is laid out as follows:

- Chapter 2: Examples of programmes running at European level
- Chapter 3: Examples of ongoing interventions at national level
- Chapter 4: Examples of projects that are operating on regional or local level
- Chapter 5 & 6: Overview of Responses and Conclusions
- Chapter 7: Index

European Level

Regarding the programmes that are being implemented at European level, examples were included which focus on the prevention of obesity or obesity and health inequalities. Chapter two is subdivided into two sections: programmes that target (school) children and their families and programmes that were set up for the general population. Furthermore, the projects described are either ‘running programmes’, ‘policy development programmes’ or ‘research studies’.

National Level

In 2006 EuroHealthNet published a document highlighting health promotion measures that had been put in place by EU Member States on national level [2]. These actions could include the implementation of national action plans, health policies or national programmes and campaigns. However, this report did not identify whether these actions acknowledged lower socio-economic communities as special risk groups or not.

The third chapter of this current report therefore reviewed the outcomes and summarizes which actions also address disadvantaged communities when the goal is to counteract obesity. In addition, further information on new developments since 2006 is provided.

Regional and Local Level

Many examples of active initiatives at the regional or local levels were found. Based on their focus they were divided over three categories: nutrition, physical activity or a combined approach.

All projects included in this report, either running at European, national, regional or local level, are described according to the following paragraphs:

- **Aim**: what is the aim (and objectives) of the project?
- **Design**: when did the project started and how was it set up? Was there a pilot phase before the project was launched? Is it based on an on-going programme or is it a new initiative?
- **Support**: where does the financial support come from? Which parties i.e. partnerships are involved?
- **Trigger**: what was the exact trigger of the project? Who was it initiated by (e.g. local authorities, government etc)?
- **Targeted Communities**: why is the project able to target the most disadvantaged communities and what are the benefits to the targeted individuals? Also, how does the project prevent that communities with a high(er) socio-economic status will profit as well and thus that the gap regarding health inequity between the two groups will increase? Does this issue get special attention, or does it not play a role?
- **Evaluation**: has the project proven to be effective? Are there any (published) reports? Are disadvantaged groups indeed targeted and are their health conditions concerning obesity improving?
- **Contact Details**: who can be contacted if further information is requested?
Report Limitations

The majority of the information considered has been taken from English language sources. When possible, reports were translated into English from other languages. Nevertheless it was difficult to obtain information from non-English speaking countries concerning initiatives being implemented at the local level, which has seldom been translated. Programmes being implemented at national or European level were more likely to be available in English.

This report does not provide an exhaustive review of innovative approaches – nor is this its aim. The role of this report is to identify examples and to stimulate debate and, where relevant, encourage practitioners to adopt innovative approaches.

Furthermore, as the information supply largely depended on the response rate of parties approached, the report is not complete in its description of national action plans, policies and campaigns being implemented at national level in European countries. It only includes those countries that were able to provide new information and that contributed to this report.

Finally, it is important to take into account that some descriptions of innovative approaches in this report are only covered very briefly. Therefore if further reading is requested, please contact the person involved.
1. Obesity and Health Inequalities

The following chapter outlines the prevalence of obesity in Europe and gives a detailed overview of the situation within the countries that contributed to this report. Furthermore health inequalities are explained: how do they evolve and how can they be counteracted? In the third paragraph health inequalities will be discussed in relation to obesity as well as the importance and relevance of addressing the obesity problem among lower socio-economic groups.

1.1 Obesity in Europe: The current situation and its long-term vision

Obesity is one of the major health challenges worldwide and it is nowadays being regarded as a pandemic [5]. Spreading obesity has been associated with growing rates of chronic diseases and is affecting longevity, especially among younger adults [6]. Data published by the World Health Organisation (WHO) and the International Association for the Study of Obesity (IASO) suggests that the number of obese people in Europe has tripled over the last 20 years and has resulted in a prevalence of 130 million obese- and 400 million overweight persons living in Europe today (figure 2).

A report recently published by Sassi et al. [7] predicts that over the next 10 years, based on the assumption that the obesity patterns would continue to evolve following the patterns observed in the past, obesity rates in OECD countries will continue to increase. Also, increases in overweight and obesity are expected to happen at a faster pace in countries where rates of obesity are historically lower (e.g. Korea, France), and may expect within the next 10 years to reach the same proportions of pre-obese population as countries that currently rank near the top, such as England.

The UK Government’s Foresight Programme, which produces together with the Horizon Scanning Centre visions of the future of key challenges for society in the UK, published a report on obesity in 2007 [8]. The aim of this project was to produce a long-term vision of how the obesity situation will look like in 40 years. Foresight modelling indicated that by 2050, 60% of adult men, 50% of adult women and about 25% of all children under 16 living in the UK could be obese. As a result, the National Health Service costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050 and the wider costs to society and business are estimated to reach £49.9 billion per year [8]. Foresight predicted that it will take at least 30 years to reverse the current obesity prevalence and before reductions in the associated diseases can be seen.
A commonly used measure to classify overweight and obesity is the Body Mass Index (BMI). It is defined as the weight in kilograms divided by the square of the height in meters (kg/m²). BMI classifications apply only to adults, as weight and height measurements of children are constantly changing through normal growth patterns.

Figure 3 and 4 present available BMI data of all European countries described in this report. The year written behind the country name represents the year of data collection.

Please note that the age range and years differ between countries and that the prevalence figures are not standardised by age. Due to these dissimilarities and differences in methodology, surveys are therefore not strictly comparable.

Lastly, self reported surveys (indicated with a '*' behind the country name) may underestimate true prevalence; e.g. women tend to under-report their weight and men over-report their height. Biases of up to 30% have been described in the prevalence levels of obesity by using these self reported heights and weights. Finally, Norway is missing in the figures as the data retrieved from IASO only included countries from the European Union.
It is important to recognise that obesity is both a medical condition and a lifestyle disorder and that these two factors have to be seen within a context of individual, family and societal functioning. Nowadays we live in a so-called ‘obesogenic’ environment; an environment which increasingly promotes a high energy intake and sedentary behaviours. Many factors influence the choices of individuals in the general population and the challenge is thus to create a supportive environment for making the healthy choices. Such an environment is linked to, and can be influenced by several key determinants, such as:

- Psychological and Cultural (e.g. religion, family influences, beliefs);
- Physically active lifestyle (e.g. social environment, access to sport/play areas, urban design);
- Nutritional (cost, taste, marketing, availability and access);
- Physiological (e.g. energy expenditure, genetic factors, pregnancy)
- Knowledge (e.g. nutrition labelling, nutrition and physical activity education through the life course); and
- Socio-economic status (e.g. education, income, social isolation, welfare)

1.2 Health inequalities and the Social Determinants of Health

Even though there has been an improvement of overall health in Europe over the past few decades, European countries are faced with substantial disparities in health within their populations. These health inequalities can be found in all European regions and can be described as ‘systematic differences in morbidity and mortality rates between people of higher and lower socio-economic status, as indicated by e.g. level of education, occupational class or income level’ [10]. As the health of those from upper classes is improving at a faster rate, the gap between high and low socio-economic communities is growing and has increased the urgency of this public health difficulty [4].

Figure 5 shows a simplified diagram explaining which factors mediate between low socio-economic status (SES) and risk of ill-health.

Health inequalities are not exclusively determined by bio-medical factors or lifestyle choices. Research has shown that health inequalities reflect structural inequalities in the distribution of wealth and resources within and between societies. Health inequalities are thus also a consequence of the social conditions that people operate in which can be defined as the social determinants of health [4]. A model which describes this in more detail can be found in a report published by the WHO Commission on the Social Determinants of Health (A Conceptual Framework for Action on the Social Determinants of Health - 2007) [11]. At last, it is not simply the poorest that experience less than optimal health; there is a social gradient of risk across society. Thus, there is a systematic correlation between social status and level of health.

Both Mackenback and the WHO’s pathways model show the complexity of health inequalities due to multi-layered factors that influence the health of an individual. Consequently, it illustrates the many difficulties one has to face when aiming to improve health equity.
1.3 Health inequalities in relation to obesity

In 1989, a review of studies published by Sobal and Stunkard [12] concluded that obesity in developing countries would essentially be a disease of the higher socio-economic classes. It would be a disease of the elite. Nowadays this view has changed as this positive association between wealth and obesity is only found among adults and children in low-income countries. The trend flattens out in middle-income countries and transforms to a negative association in high-income countries, where the obesity risk is thus higher among lower socio-economic groups [13]. In addition, evidence suggests that the difference between socio-economic groups is widening, i.e. the gradient is becoming steeper [5].

There are several reasons why a relation between socio-economic status and obesity is relevant. First of all, a study by Robertson, Lobstein and Knai [9] (currently in press) showed that there is a consistent and profound social gradient in the prevalence of obesity in countries in Western Europe. Some 20-25% of the obesity found in men, and some 40-50% of the obesity found in women can be attributed to differences in socio-economic status. Worldwide, and on average also in the OECD area, gender seems to have an affect on obesity prevalence as women in lower socio-economic groups (SEGs) tend to show higher obesity rates compared to men [figure 6] [6,7]. This might be due to different lifestyle choices (e.g. smoking, alcohol abuse) or environmental pressures (e.g. discrimination in employment; family gate-keeper; and lower self-esteem associated with a failure to meet societal norms and models) [7,9].

Obesity and overweight among children is also associated with the socio-economic status of their parents [9]. Women belonging to disadvantaged socio-economic groups are more likely to give birth to under- and over-weight babies (both are risk factors for later obesity) and are less likely follow recommended breastfeeding and infant feeding practices (also linked to obesity risk) [9]. Their children will in turn have fewer chances of moving up the social ladder, perpetuating the link between obesity and socio-economic disadvantage [7].

Source: Sassi et al. (2009)

Figure 6: Upper figure: odds ratios for obesity (vertical axis) in men by SEG
Lower figure: odds ratios for obesity (vertical axis) in women by SEG
The lighter the vertical bar, the lower the socio-economic group (SEG)
Also, evidence of social inequalities within populations is matched by evidence between populations: those Member States with higher levels of social inequality (e.g. income inequalities or proportion of the population living in relative poverty) tend to have the highest levels of obesity in the population, especially among adolescents and children [9]. Besides this, ethnicity plays a role as well. Wardle et al. [14] showed that, even after controlling for differences in socio-economic conditions, women in certain ethnic minority groups are substantially more likely to be obese than other women. However, not all minority groups display higher rates of overweight and obesity.

A recently published study by Braveland (2009) [15] suggested that material disadvantage, e.g. as a result of low income, also affects obesity prevalence. It can influence the ability to purchase nutritious food or to live in a neighbourhood with safe, pleasant places to exercise and markets that sell affordable healthy products. Robertson et al. found that food eaten by people in the lower SEGs are higher in energy and lower in micronutrients compared with higher SEGs. Also, members of low socio-economic groups eat less vegetables and fruit and children drink more soft drinks than those from higher classes. In general, adults and children, especially girls, from lower SEGs are less active and more sedentary [9]. In addition to this, material hardship could also increase obesity risk as it is a source of chronic stress. This might in turn limit people’s ability to change weight related behaviours - even when informed and motivated [15, 16].

Finally, Sassi et al. suggested that disparities by education among women (in OECD countries) have an effect on overweight and obesity rates as well [7], as more educated and higher socio-economic status women display substantially lower overweight and obesity rates. However, mixed patterns are observed among men. This finding is supported by the WHO MONICA project, which monitored during ten years, ten million men and women living in 21 countries (14 in the European region). It found that higher educational levels were linked to lower BMIs in about half of the population groups with respect to men, and in almost all of the groups with respect to women [9, 17].

In conclusion, around the world obesity and overweight are thus reaching pandemic proportions and they especially affect disadvantaged communities. Explanations limited to lifestyle causes such as diet and exercise are inadequate as there are many more complex underlying factors (e.g. genetic, physiological, psychological, social, economic, educational etc.). Better understanding of the complexity of causation is therefore needed and interventions that address the prevention and treatment of obesity and overweight at multiple levels across the gradient are of great importance. By sharing evidence, success factors of strategies can be identified that hopefully contribute to a reduction of the social gradient in obesity.
2. Projects at European Level

Several projects are implemented at European level aiming to counteract the obesity pandemic and to improve health equity. This chapter is subdivided into two sections; (1) Programmes that target (school) children and their families, and (2) Projects that were set up for the general European population. Furthermore, these two sections are divided into several paragraphs. ‘Running programmes’ gives an overview of ongoing projects at European level. ‘Policy development’ describes approaches that effectively evaluated or developed policy projects throughout Europe. Finally, a third paragraph consists of examples of research studies – projects with scientific objectives. The aim of these studies is to gain insight into, or increase our understanding of people’s health, health behaviours and their social context.

2.1 (School) Children in Europe

2.1.1 Running programmes
- School Fruit Scheme
- MEND Project
- EPODE

2.1.2 Policy development
- Schools for Health in Europe (SHE) Network
- Shape Up
- HEPS

2.1.3 Research studies
- Pro Children Project
- Health Behaviour in School-aged Children (HBSC)
- ENERGY Project

2.2 Overall European population

2.2.1 Policy development
- HOPE Project
- EURO-PREVOB
- Teenage Project

2.2.2 Research studies
- HELENA Study
- Eurothine Project
2.1 (School) Children in Europe

2.1.1 Running Programmes

The School Fruit Scheme is a European Union-wide scheme to provide fruit and vegetables to school children. European funds worth €90 million every year will pay for the purchase and distribution of fresh fruit and vegetables to schools. This money will be matched by national and private funds in those Member States which chose to make use of the programme. Besides providing fruit and vegetables to a target group of schoolchildren, the scheme will require participating Member States to set up strategies including educational and awareness-raising initiatives and the sharing of best practice.

The proposal for a School Fruit Scheme follows an undertaking made during the negotiations on the reform of the Common Market Organisation for fruit and vegetables in June 2007. Since then, the Commission has engaged in a wide-ranging public consultation and an in-depth impact assessment of different options. The scheme will begin at the start of the 2009/2010 school year.

**Aim:** The overall aim of an EU SFS is to provide a policy and funding framework for Member State initiatives, to durably increase the share of fruit and vegetables in the diets of children, at the stage when their eating habits are formed. This represents an investment, which would in the future help reduce public health costs resulting from poor diet.

The main specific aims would be to arrest declining consumption of fruit and vegetables, increase long-term consumption among children, foster healthy eating habits that continue into adulthood; enable a significant number of schoolchildren to eat fruit and vegetables, so providing equal opportunities for all children in the EU and contributing to social cohesion.

**Support:** The Commission is putting on the table €90 million per year for the provision of fruit and vegetables in schools. Governments would have the choice of whether to participate or not. The programmes would be co-financed, either on a 50/50 basis, or 75/25 in the so-called 'convergence regions', where GDP/capita is lower, as well as outermost regions. Member States can if they wish require a compulsory parental contribution. This money could not be used to replace existing national financing, but would encourage additional activities, be it linked to existing programmes or creating completely new initiatives. And Member States could of course add extra money if they wanted to. National authorities would have to draw up a strategy in conjunction with public health and education authorities, also involving the industry and interest groups, tailored of course to national preferences.

**Trigger:** Weight problems and obesity are increasing in the European Union, especially among children: an estimated 22 million children in the EU are overweight and 5.1 million of these are obese (EU-25). This figure is expected to rise by 400,000 per year (point 3.3 Impact assessment report). Improved nutrition can play an important part in combating this problem.
Experts agree that a healthy diet can play an integral role in reducing obesity rates, and cutting the risk of serious health problems – such as cardiovascular disease and diabetes 2 – in later life \[13\]. Key to this is the consumption of sufficient amounts of fruit and vegetables. The World Health Organisation recommends a daily net intake of 400 grams of fruit and vegetables per person. The majority of Europeans fail to meet this target and the downward trend is particularly evident among the young.

Studies show that healthy eating habits are formed in childhood. People who eat a lot of fruit and vegetables in childhood remain good consumers. Those who eat little tend not to change their ways and also pass on their habits to their own children. Research has also shown that families with a lower level of income tend to consume less fruit and vegetables. As such, the free provision in schools of these healthy products can make a real difference, particularly in underprivileged areas \[13\].

**Targeted Communities:** Studies show that healthy eating habits are formed in childhood. People who eat a lot of fruit and vegetables in childhood remain good consumers. Those who eat little tend not to change their ways and also pass on their habits to their own children. Research has also shown that families with a lower level of income tend to consume less fruit and vegetables. As such, the free provision in schools of these healthy products can make a real difference, particularly in underprivileged areas.

**Evaluation:** Studies show that, as long as certain conditions are met, School Fruit Schemes are an effective tool to durably increase the consumption of fruit and vegetables. In particular, it is proven that a School Fruit Scheme should not only (some say even not mainly) concentrate on the provision of fruit and vegetables at educational establishments (schools) but also include a set of accompanying measures aimed at awareness raising \(\text{(point 4 of the Impact assessment report)\[13\]}\).

Encouragement will also be given to networking between different national authorities which run successful school fruit schemes. These already exist in some EU countries, and take many different forms. But there is much more that can be done and this EU scheme provides a perfect basis to get new programmes off the ground \[13\].

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MEND is an abbreviation for Mind, Exercise, Nutrition...Do it! It is an organisation dedicated to reducing global childhood overweight and obesity levels by working in partnership with local, regional, national and international partners from the private, public and voluntary sectors. MEND provides evidence-based, family-oriented programmes to prevent and treat obesity, and is training frontline staff in obesity management to build local capacity and skills.

The Project is the first clinically proven community-based UK child weight management programme to operate in a scalable and cost-effective manner. It is supported by very successful research to date, including a feasibility study, pilot and Randomised Controlled Trial (RCT). The successful MEND Programme was devised at the world renowned Great Ormond Street Hospital for Children NHS Trust and the University College London Institute of Child Health. To date, families are taking part in more than 300 programmes across the UK every term and work is now taken to other countries, including Australia, New Zealand, Denmark and the United States.

Free community-based healthy living programmes are offered to families, based on the age of the children. The MEND Programme was set up for 7-13 year olds whose weight is above the healthy range for their age and height, and the Mini-MEND Programme targets 2-4 year olds, irrespective of their weight.

The MEND Programme runs twice a week after school in two-hour sessions over 10 weeks. Developed by child health experts, the programme helps and supports children and their families to manage their weight by teaching them how to change their behaviours around healthy eating and physical activity. The 20 MEND Programme sessions each include an hour’s workshop for children and parents, and an hour’s exercise for the children whilst the parents have an adult discussion. Measurements are taken before and after the Programme and there is follow-up contact including a graduate website, newsletters, reunion events and telephone support.

Developed by experts in child health, the Mini-MEND Programme is a course for parents or carers with children aged 2 to 4. It offers a fun and creative environment for families to learn how to make healthier lifestyle choices and ensure their children have the best possible start in life. Each lasting 90 minutes, Mini-MEND’s ten weekly sessions combine parent-toddler active play, parent discussion groups and children’s crèche-style creative play activities. They take place during the daytime at community venues such as leisure centres and Sure Start Children’s Centres.
Mini-MEND helps to encourage young children to try new things and shows parents creative ways to get their children to taste and enjoy different fruits, vegetables and other healthy snacks. Also, the active play sessions provides ideas and tips for games which will keep the children moving and occupied. As well as helping to improve agility, balance and co-ordination, the programme also works on building their confidence.

MEND also provides **Child Obesity Awareness Training Seminars** to frontline obesity management staff. This informative day includes:

- a comprehensive overview of childhood obesity, including its assessment
- a discussion around national guidance on tackling obesity
- practical strategies to explore the issue with families, such as raising the issue of weight
- essentials of obesity management including guidance relating to nutrition, physical activity and behaviour change techniques
- a brief overview of current child obesity interventions including the MEND Programme

Experienced trainers will come to a location of choice and up to 30 delegates can be accommodated on each seminar. The training is aimed at health professionals, community practitioners and front-line staff but former participants include:

- School and GP practice nurses
- Teachers and teaching assistants
- Extended Schools and Healthy Schools staff
- Sure Start Children’s Centre staff
- Early years practitioners
- Dieticians and nutritionists
- Health visitors and nursery nurses
- Outreach and support workers
- Mental health practitioners
- Fitness instructors and sports coaches
- Sports development professionals
- Youth workers
- Students
MEND in the UK

MEND Programmes have been running in the UK since 2005. They are available in more than 300 locations every term across the UK including sites in Wales, Scotland and Northern Ireland. They usually take place after school, in schools and leisure centres. A smaller but growing number of Mini-MEND Programmes are also running. These run in community venues such as Sure Start Children’s centres and typically take place during the day.

MEND in the US

In 2008, the 10 week MEND Program was adapted for the US – culturally and from a dietetic and policy perspective – and a first Field Study was completed successfully in partnership with the City of New York’s Department of Parks and Recreation and SPARK PE. A Spanish language version will also be available from April 2009.

MEND in Australia

The MEND Programme has been adapted for use in Australia and is currently being delivered at a number of sites in Victoria. The Minister of Health has indicated that MEND is a preferred provider of child obesity treatment services for the State of Victoria and New South Wales. Currently the organisation is in discussion with a number of other States with a view to extending the network of MEND Programmes across the country.

MEND in Denmark

The MEND Programme has been adapted for use in Denmark in partnership with the Oxford Health Alliance (OxHA) and is currently being evaluated through a government-funded grant.

Aim:
The organisation’s mission is to enable a significant, measurable and sustainable reduction in global childhood overweight and obesity levels. They aim to achieve this by:

- Developing effective and research-based obesity prevention and treatment programmes, training and resources
- Working alongside partners from the private, public, voluntary and academic sectors to make our services available at a community level on the widest possible scale
- Training people who come into contact with overweight and obese children so they can provide families with the best possible support
- Building one of the largest bodies of evidence worldwide on child obesity prevention and treatment
Support: The organisation has a 20-year research partnership with Great Ormond Street Hospital for Children NHS Trust and University College London Institute of Child Health. Funding partners are Big Lottery Fund, Bromley Mytime, FitPro, Legal and General, Nutricia, Britvic, Sainsbury’s, Sport England, Youth Sport Trust and National Sports Foundation.

Trigger: Currently there are 155 million overweight and obese children worldwide, 3 million of whom live in the UK and 25 million in the United States. Obesity causes needless suffering, as well as massive financial and social consequences. But it can be prevented and treated. Thousands of families have proved this through this life-changing programme.

Targeted Communities: The MEND Programme targets 7-13 year olds whose weight is above the healthy range for their age and height, and the Mini-MEND programme targets 2-4 year olds, whatever their weight is.

Evaluation: The programme is supported by very successful research to date, including a feasibility study, pilot and Randomised Controlled Trial (RCT). This Trial shows that the MEND Programme helps children lose weight, increases their physical activity levels and self esteem and reduces their sedentary behaviours e.g. screen time. These results continue to improve over time after the end of the core Programme. Children demonstrate sustained health improvements 12 months after starting the MEND Programme and the RCT concluded that: ‘The sustained benefits of the MEND intervention suggest that this is an effective and feasible community-based programme for childhood obesity.’

Currently the organisation is conducting a second, larger RCT at the Institute of Child Health to follow families for longer periods to see how they are faring 2, 5 and 10 years after starting the Programme.

The programmes that are running in Denmark and Australia have demonstrated that the MEND is effective in other countries and languages as well.

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EPODE (Together Let’s Prevent Childhood Obesity - Ensemble Prévenons l’Obésité Des Enfants) is a methodology designed to involve all relevant local stakeholders in an integrated and concrete prevention program aimed at facilitating the adoption of healthier lifestyles in the everyday life. The programmes developed on the basis of the EPODE framework are long term, aimed at changing the environment and thereby the unhealthy behaviours. The approach is ‘positive, concrete and stepwise’ learning process with no stigmatization of any culture, food habits, overweight and obesity.

The first EPODE programme started in France in 2003 - Initiated by mayors who first developed the pilot program. EPODE now extends to nearly 1.8 million inhabitants in 167 French cities, 31 cities in Spain (THAO Salud Infantil Programa) and 8 cities in Belgium (VIASANO Program). Success to date is measured by a large field mobilization in the pilot cities and by the encouraging evolution of the BMI of children in France within the pilot cities. EPODE is about to be implemented in Greece, Québec (Canada) and in Australia. The national coordination team recruits motivated cities. Recently, the EPODE program has also been referenced as a case study within the “healthy weight, healthy lives” cross a government strategy in England (HM Government, January 2008).

The model consists of the strategic set up and coordination at a national and local level of concrete initiatives fostering pleasant and balanced eating habits and greater physical activity in everyday life. The methodology enables the creation of new educational schemes mobilizing local stakeholders (health professionals, teachers, parents, catering services, local producers...) within their daily activities, to empower families and individuals in a sustainable way. These actions are coordinated by a local project manager, nominated by the mayor (or other local leader) and delivered under the lead, at the national level, of a social marketing team and the expertise of an independent scientific committee.

Being community-based makes the EPODE approach successful at the local level. Feeling to be part of a common positive initiative makes the local stakeholders and families’ motivation to get involved in the programme increase. Moreover, involving local stakeholders enables giving easy-to-get messages for healthier lifestyles promotion. It also requires a cross-cutting engagement within a municipality, which is not so easy to settle. High degree of motivation and commitment are key words for the programme’s success.

Figure 11: Parties involved for the implementation of the EPODE programme

Source: Protéines ©
The themes developed for the past 4 years in France were all linked to the objectives of the National Nutrition Program the French government is developing: Fruits and vegetables, starchy products and pulses, drinking water and less sugary drinks, cooking easily a balanced meal with little money, portion sizes and meals structures, enjoying eating properly treats. In parallel, 4 themes have focused on being more physical active, such as approaches based on “just playing with a friend” or in school yards or reducing time spent in front of screens. Structural goals are also pursued such as the creation of secured playgrounds in lower income neighbourhoods, adapting school meals and environment, offering a non-competitive sport practice for all the families, etc.

Based on EPODE (France)/ THAO (Spain)/ VIASANO (Belgium) pilot experiences, the EPODE European Network (EEN) is a European project to be run from 2008 to 2011 with the support of the European Commission (DG SANCO) and the collaboration of 4 European universities and private partners, in order to facilitate the deployment of the EPODE methodology in other European countries. It exchanges and shares information of project engineering practices.

**Aim:** The objective is to foster healthier lifestyles and contribute to the reduction of childhood overweight and obesity through a methodology that establishes prevention at the heart of the city networks. The 4 pillars of EPODE are: strong political will, a sound scientific background, a social marketing approach and multi stakeholder approach.

**Support:** Three kinds of private partnerships are possible within the programme:

- At national level: big companies contribute significantly to the funding of the activities of the national coordination team;
- At a local level: two types
  1. “all-the-year” partners are the ones who contribute to the development of the programme; and
  2. “occasional” partners are the ones who contribute to occasional local actions (e.g. “week of the bread” event in a city)

EPODE brings together representatives from commercial sector to the private non-for-profit sector (NGOs), the academic world and local and national elected authorities in a series of successful and meaningful multi stakeholder partnerships. The programme is jointly provided by both commercial and public sectors through regional and or local public entities. The cost is evaluated as 2 to 4 EUROS per year per inhabitant altogether in a mature phase.

One Euro per year per inhabitant is funded by the commercial sector and finances mainly activities of the national coordination team, e.g. its productions and coordination expenses. The rest of the funding is provided by the cities, which budget is bearing the cost of the fulltime project manager plus all local expenses: publishing materials, subsidies to NGOs taking part to some actions, yearly events, etc.

**Trigger:** The pandemic of obesity in young people threatens to provoke a massive increase of numerous health complications. Nearly two thirds of children with obesity will continue to suffer from this health condition throughout their life. Overweight and Obesity are the main risk factors for disabling and life-threatening health conditions in young people, including type 2 diabetes, cardiovascular complications, some cancers and also psychological pathologies.

Over the last ten years, studies have demonstrated that the prevention of overweight and obesity is possible through interventions that are based on lifestyle and environment – particularly food and physical activity interventions. However, there is a clear need to bridge the gap that exists between awareness and knowhow: it is widely known that people need to be more physically active and have a healthy diet. The concrete way to effectively implement the necessary related lifestyles changes and, ensure sustainability is still challenged.

The EPODE Programme was developed in France in 2003 by mayors and is inspired by the experience developed in previous community and school-based interventions. It is based on key considerations: preventing a child from
becoming obese by acting on the behaviour of the whole family, changing its environment and social norms.

**Targeted Communities:** Children (and their families) living in Europe.

**Evaluation:** Sociological evaluations focusing on the perception of EPODE in families and local stakeholders indicate particularly that the program is seen as a common positive action for the community, a “healthy lifestyle” program and a concrete aid that helps parents to guide and support their educational role towards their children.

Since its launch in 2004, more than 1,000 actions per year have been implemented thanks to a large field mobilization in the French pilot cities by the local stakeholders.

As part of the project assessment, all EPODE communities measure and weigh children annually. The first assessment for the 10 communities (2005) is the one that will serve as a reference to assess the procedure at its conclusion, shows an average rate of prevalence of overweight and obesity of 20.6% for all the towns, with rates varying from town to town between 10% and 25%. As in the other studies, a clear correlation is observed between the socio-economic level of the population and the obesity rate. The least affluent neighbourhoods and towns are most at risk.

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2.1.2 Policy Development

The Schools for Health in Europe network (SHE network) is the European platform for school health promotion. The network is coordinated by NIGZ, as a WHO Collaborating Centre for School Health Promotion.

The SHE network has a longstanding history and was formerly known as the European Network for Health Promoting Schools (ENHPS). Since 1992 it operates in 43 countries in the European region. It has demonstrated progress in establishing school health promotion as part of the core work of schools in several member countries. SHE makes progress in increasing the cooperation between the health sector and the education sector and focuses on making school health promotion a more integral part of policy development in both sectors in Europe.

The SHE approach for school health promotion in Europe is based on the following five core values and five pillars. SHE uses a positive concept of health and well-being and acknowledges the UN Convention on the Rights of the Child. The SHE core values and pillars are a source of inspiration and provide a basis for health promoting school developments.

The five SHE core values are:

1. **Equity** Health promoting schools ensure equal access for all to the full range of educational and health opportunities. In this way they have the potential to reduce inequalities in health.
2. **Sustainability** Health promoting schools acknowledge that health, education and development are closely linked. Schools act as centres of academic learning and support to develop a responsible and positive view on pupil’s future role in society.

Health promoting schools develop best when efforts and achievements are implemented in a systematic way for a prolonged period, for at least 5-7 years. Outcomes (both in health and educational) mostly occur in the medium or long term.

3. **Inclusion** Health promoting schools celebrate diversity and ensure that schools are communities of learning, where all feel trusted and respected. Good relationships among pupils, between pupils and school staff and between school, parents and the school community are important.

4. **Empowerment and action competence** Health promoting schools enable children, young people and all members of the school community to be actively involved in setting health-related aims and in taking actions at school and community level, to reach these aims.

5. **Democracy** Health promoting schools are based on democratic values and practice the use of rights and responsibilities.

The five SHE pillars that underpin the health promoting school approach are:

1. **Whole school approach to health** There is a coherence between the school’s policies and practices in the following areas which is acknowledged and understood by the whole school community:
   - a participatory and action-oriented health education;
   - taking into account student’s own concept of health;
   - healthy school policies;
   - the physical and social environment of the school;
   - life competencies;
   - links with home and the community;
   - health services.

2. **Participation** A sense of ownership is fostered by student, staff and parent through participation and meaningful engagement, which is a prerequisite for the effectiveness of health promoting activities in schools.
3. **School quality** Health promoting schools create better teaching and learning processes. Healthy students learn better, healthy teachers and non-teaching staff work better and have a higher job satisfaction. The school’s main task is maximizing school outcomes. Health promoting schools support schools in achieving their educational and social goals.

4. **Evidence** Schools for health in Europe are informed by existing and emerging research and evidence focused on effective approaches and practice in school health promotion, both on health topics (e.g. mental health, eating, substance use), and on the whole-school approach.

5. **Schools and communities** Health promoting schools are part of the surrounding community. They endorse active collaboration between the school and the community and are active agents in strengthening social capital and health literacy.

SHE encourages each member country to develop and implement a national policy on school health promotion, building on the experiences within the country, within Europe and abroad. Such a policy is also supported by enabling schools to actively take part in a wider community in Europe. SHE network expands and further explores the European dimension of health promoting schools which has already received wide recognition globally as one of the leading international network on school health promotion.

Its methods of working are:

- to act as the platform for professionals active in the area of school health promotion;
- to stimulate professional exchange on theoretical, conceptual and methodological development in the area of school health promotion, including research and good practice;
- to facilitate exchange of learning and practice between individual schools and students in different member countries as appropriate;
- to stimulate the development and extension of partnerships between the health sector, the education sector, the youth care sector and other appropriate sectors at the European and national level

**Aim:** The main aim of the Schools for Health in Europe network is to act as the European platform for school health promotion by supporting organisations and professionals to further develop and implement school health promotion.

The Schools for Health in Europe network:

- provides information;
- encourages research;
- shares good practice, expertise and skills; and
- advocates for school health

**Support:** The network receives support from the Council of Europe, the European Commission and WHO Regional Office for Europe.

**Trigger:** In Europe it is generally accepted that every child has a right to education, health and security. This is also formally recognised in global documents such as the Convention on the Rights of the Child (United Nations, 1989). Clearly the central role of schools is learning and teaching. Schools also
have great potential to promote the health and development of children, young people, families and all of the school community including the staff. A strategy built on the health-promoting schools approach helps school communities to:

- manage health and social issues;
- enhance student learning;
- improve school effectiveness

**Targeted Communities:** Schools are an important setting for children, where they can learn and develop skills to improve their health. The network uses an innovative programme, introducing new ideas and approaches to school health promotion. The network has focused on positively influencing the health and health behaviour of school age children (aged 4-18 years) and school staff in Europe by developing and implementing quality-based and evidence-based health promotion programmes for the school setting.

The Schools for Health in Europe network is of interest to those working in the health sector, the education sector, the youth care sector and other relating sectors. Membership for the Schools for Health in Europe network is open for any organisation or professional with an interest in schools and health.

**Evaluation:** Experience over the last 15 years has shown that a systematic process of partnership-working, advocacy, planning, developing and implementation of the programme and providing technical support, are key components for success.

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The 3-year European framework project Shape Up (2006-2008) proposes a new approach to promote a healthy and balanced growing up.

Shape Up involves the school and community, including families, from the start, jointly with the child. To promote healthy habits requires new ideas to convey a broader vision of the benefits of a balanced diet and regular physical activity, focusing on a positive and critical view of food and body movement:

- **Child participation.** Shape Up is not merely about involving children in pre-defined school-based or community-based activities, but also having them decide about the type of activities they want to implement. Participation is also about letting them decide for themselves the types of games, sports and other activities that most appeal to them.

- **School-community collaboration.** Shape Up is not only child-centred; it also involves the school and community, including families, from the start, jointly with the child. It provides an opportunity for them all to think and talk about their lifestyles and living conditions and what they can do together to improve them.

- **Research.** Shape Up is based on in-depth research, and will form a basis for further investigation. Research linked to the project will help to determine what works within specific contexts, and what is learnt from this experience will inform future health promotion activities.

- **No stigma.** Shape Up will focus on a positive and critical view of food and body movement.

- **Capacity building.** Shape Up will co-fund the recruitment of two dedicated staff members in each city. These staff members will be responsible for training local community partners and monitoring the project at a city level over its three-year duration. Five European competence centres have joined forces to bring new expertise to the cities.

- **City involvement.** Shape Up will provide practical assistance to children in order to bring about changes in the daily life of the city. A Shape Up promoting group will be convened with the support of the city council to assist children, families and schools with the development of initiatives.

- **More resources.** Shape Up will provide guidelines, materials and finance for specific health-promoting actions both in and out of school.

- **Measuring success.** The Shape Up process, together with its results and achievements, will be evaluated in order to demonstrate the validity of its innovative approach.

- **European collaboration.** Cities are not alone, as 26 cities all over Europe are taking part in Shape Up. Imagine the opportunities for new exchanges, twinning, and the discovery of new cultural environments.

- **Spreading the message.** Shape Up results will be communicated to all interested cities.

Shape Up is a direct response to the commitment for action taken by the EU Platform on Diet, Physical Activity and Health. It fits into the Health Determinants priority area of the Work Plan 2005 and directly responds to the strategic necessities expressed in the Public Health Programme. Shape Up will moreover strengthen links with the European Network of Health Promoting Schools (a joint initiative of the WHO, the European Commission and the Council of Europe) which acts as a collaborating partner. A common European framework of action is both necessary and feasible. Not only do European schools share common features and limitations (curriculum constraints, training necessities), but they also offer a huge potential for intercultural collaboration in seeking adequate solutions to a common problem. Education is a key field of action, hence the need to give a leading role to schools. European Commission co-financing will directly revert benefits to the major EU initiatives in the field. It is also a prerequisite for three main reasons.
A team of researchers from the Research Programme for Environmental and Health Education at the Danish University of Education is responsible for designing and researching the methodological framework for Shape Up. The framework is based on evidence in democratic health education and health promoting schools research. The following research findings provide the basis for the Shape Up methodological approach:

- Ownership and empowerment are key elements of effective health promotion programmes;
- In order to adopt healthy lifestyles and to acquire competence to bring about health-promoting changes, children and young people need to be guided to develop action-oriented knowledge about health, eating and body movement;
- Action-oriented knowledge is multidisciplinary and multidimensional;
- Action-oriented knowledge can only be gained through participation in taking concrete health-promoting actions individually or collectively, and through participation which is guided by competence adults and adequate organizations structures in school and community;
- Effective participatory school-work involves collaboration between school and local community and cross-cultural exchange.

The main characteristics of the Shape Up methodological framework are:

- It is a framework, rather than a static step-by-step method. The aim is to suggest new ideas and participatory ways to work with the issues of food, physical exercise and health. Our wish is to inspire teachers, Shape Up facilitators, coordinators and the other Shape Up staff to explore, test and modify these ideas in their specific contexts, cultures and environments.
- The methodological framework itself is developed in participatory ways. In designing the framework we have taken as a starting point the ideas and opinions about health, food and physical activity of children and young people from different countries. Furthermore, we have asked teachers, local stakeholders and the national coordinators of the European Network of Health Promoting Schools to give us feedback on the initial methodological guidelines and their inputs are integrated in the final design.

The methodological guidelines include theoretical explanations, children and young people's ideas and case stories from practice, organised in the following topics:

- The innovative participatory model – IVAC (Investigation; Vision; Action, Change) and actions to address the root causes of obesity;
- The concepts of health, food and physical activity;
- Participation of children and young people in health matters that concern them;
- School-community collaboration;
- International collaboration;
- Self evaluation and learning from experience.

The methodological guideline publication is supplemented with a lot of activity examples and other practical resources within the “Pedagogical Material” section of this portal, which will be updated regularly as the project goes along.

Shape Up is based on a European networking strategy to convince as many European schools as possible to share this common framework and join the Shape Up community. A European Shape Up portal will sustain all aspects of the strategy. European co-financing is crucial to encourage such an intensive use of ICT - especially in the less-equipped member states - and favour virtual twinning between schools to exchange experiences and practices and find mutual inspiration to develop their own health promotion strategies.

Shape Up is a project totally European, covering progressively all 25 member states. This geographical coverage will fully account for the impact of cultural and geographical diversity. We have paid special attention to selecting different environment to assess the impact of immigration, deprived economies, semi-
urban settings, highly urbanized areas, medium-high level of incomes, sustainable urban planning policies... Validity of results will be reinforced.

Shape Up as an educational programme must also account for the diversity of schools’ education systems in terms of curriculum, length of school day, ICT equipment, school meal policy... The diversity of European school systems conditions any Shape Up’s extension to country-by-country validation based on experimental results.

Aim: The fundamental premise of Shape Up is that promoting goods habits to a healthier life among the youth requires new messages to convey a broader vision of sound nutrition and regular physical exercise.

Shape Up aims to:

- Bring together the principles of health education, prevention and promotion in an integrated programme,
- Promote health and wellbeing;
- Tackle social and environmental health determinants;
- Involve schools and local communities in constructive dialogue and action planning concerning health education and promotion;
- Enhance children’s and young people’s competences to carry out health promoting actions and bring about positive changes;
- Undertake health-promoting actions at the local level, initiated through schools by children and youth, in collaboration with local stakeholders;
- Empower a European network of schools and local actors in all the member states.

Support: Shape Up is a European research framework involving research institutions from 6 European countries; no other entity than the European Commission can support and fund such a partnership. Health Education, urban planning, social capital, intergenerational dialog, ICT in school are all central to the EU and Shape Up’s results will benefit each of these areas.

Shape Up requires an experimental implementation progressively covering over the 3-year programme all 25 member states. No other co-financing can be found to support this cross-cultural programme with the presence of all new member states, create European-wide capacity building, and lead complex evaluation processes. Moreover, all participating cities justify their financial contribution in view of the EU recognition they will receive by participating in a project.

The Danish University of Education and P.A.U. Education are responsible for the coordination of the project.

Regional coordination

- Northern Europe: The Danish University of Education (Denmark)
- Central and Eastern Europe: Schulen ans Netz (Bonn, Germany)
- Southern Europe: P.A.U. Education (Barcelona, Spain)

Competence centres

- The Danish University of Education: Research and Methods
- P.A.U. Education (Barcelona, Spain): Coordination, Community building, Dissemination and Portal
- ABCittà (Milan, Italy): Training
- Schulen ans Netz (Bonn, Germany): ICT at school and Portal
- The University of Hull (Hull, United Kingdom): Evaluation

Supporting partners

- European Commission - Directorate General for Health and Consumer Affairs (DG SANCO)
- Kraft Cares (Kraft Foods)

Trigger: It was submitted to the Public Health 2005 call for proposals launched by the European Commission Directorate General for Health and Consumer Affairs.
The HEPS Project started on 1st May 2008 and wants to contribute to reducing childhood obesity through effective national policy in the EU member countries and improved practice in the school setting. Across member states there are many initiatives on reducing the prevalence of overweight among school-aged children with a practical focus towards developing activities, programmes and teaching methods. However, currently no EU member state has an effective national school policy in operation. HEPS aims to bridge this gap by being a policy development project on a national level across Europe. HEPS will help to implement these programmes in a sustainable way at school level. Unique for HEPS is that it will evaluate its impact on national policy in the EU member states.

To achieve its aim, the HEPS Schoolkit will be developed in the three year time period. The HEPS Schoolkit will help member states develop national policy to promote healthy eating and physical activity in schools based on the health promoting school approach. The HEPS Schoolkit consists of the following six components:

- **HEPS guidelines**: a set of principles on promoting healthy eating and physical activity in schools, meant for organisations working on the national level in Europe;
- **HEPS advocacy guide**: a tool assisting those advocating for the development of national school policy towards promoting healthy eating and physical activity;
- **HEPS inventory tool**: a set of quality criteria for school programmes on promoting healthy eating and physical activity;
- **HEPS tool for schools**: a manual that will help schools in the member nations to introduce and implement a school programme on promoting healthy eating and physical activity;
- **HEPS teacher training resource**: a programme that will be used to train teacher trainers in promoting healthy eating and physical activity in schools;
- **HEPS monitoring tool**: used to monitor how effectively the HEPS Schoolkit is being implemented in each member state.

**Aim:** The general objectives of the HEPS Project are:

1. to develop, implement and evaluate an effective national policy and sustainable practices on healthy eating and physical activity in schools in all EU member states
2. to support the development and implementation of comprehensive, sustainable and evidence-based school programmes in the member states to combat and prevent overweight among school-aged children in the most efficient way by developing and implementing guiding principles and tools to promote healthy eating and physical activity in schools

**Support:** The HEPS Project is a three year project which started on 1st May 2008. It is co-funded by the European Commission, DG Sanco.

The NIGZ is coordinating the HEPS Project in collaboration with:

- Free university of Brussels, Belgium
- Welsh Assembly Government, Wales
- Danish School of Education, Aarhus University, Denmark
- Institute for Child Health, Greece
- University Maastricht, Netherlands

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1 Preventing overweight in this context means: promoting healthy eating and physical activity, including mental health aspects
NHS Health Scotland
Warsaw University, Poland
University of Bergen, Norway
Leuphana University Lüneburg, Germany
National University of Ireland, Galway, Ireland
Ludwig Boltzmann Gesellschaft, Austria
State Environmental Health Centre, Ministry of Health, Lithuania

**Trigger:** In Europe close to one in four school children are overweight, with numbers rapidly increasing. An integrated approach is required to stop this trend. Across member states there are many initiatives on reducing the prevalence of overweight among school-aged children with a practical focus towards developing activities, programmes and teaching methods. However, currently no EU member state has effective national school policy in operation. HEPS aims to bridge this gap by being a policy development project on a national level across Europe. HEPS introduces the health promoting school approach as a new way of developing school health policy.

Moreover, the HEPS Project is connected with the Schools for Health in Europe (SHE) network. SHE-coordinators will be able to give their input during the HEPS Project and profit from the outcomes. At the same time they are the key figures who will implement the HEPS Schoolkit in their own country.

**Targeted Communities:** In Europe it is generally accepted that every child has a right to education, health and security. Schools can contribute to improve children’s health by promoting healthy eating and physical activity and by encouraging their participation and training their skills. A strategy built on the health promoting school approach helps school communities to:

- manage health and social issues;
- enhance student learning;
- improve school effectiveness

One of the core values for health promoting schools is equity: that all children and young people have equal access to health and to develop health literacy. This is one of the founding principles - that is built into the HEPS Schoolkit. Furthermore, in the health promoting school approach the school plays a central role. The health programmes and activities are carefully chosen to meet the specific needs of the school, which is important to reach the target group in an effective way.

**Evaluation:** In the 3rd year the impact of the HEPS Schoolkit on national and regional policy development on promoting healthy eating and physical activity in schools will be assessed.

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2.1.3 Research Studies

The Pro Children Project was designed to provide information on actual consumption levels of vegetables and fruits in European schoolchildren and their parents, to understand the determinants of consumption patterns among the children, and to develop and test effective strategies to promote adequate consumption levels of fruits and vegetables among schoolchildren. The project consists of two phases. In the first phase, relevant information for the planned development and implementation of fruit- and vegetable-promoting interventions is gathered. In the second phase, the planned interventions are developed, implemented and evaluated in group-randomized field studies. The first phase is conducted in 9 participating countries, i.e. in Austria, Belgium, Denmark, Iceland, the Netherlands, Norway, Portugal, Spain and Sweden, while the second phase is restricted to 3 countries, i.e. Spain, the Netherlands and Norway, as efficacy will have to be established prior to broader dissemination.

**Aim:** The specific research objectives are:

**Assessing fruit and vegetable consumption and correlates of consumption levels**
- To develop valid and reliable instruments for assessing fruit and vegetable consumption among schoolchildren and parents
- To develop valid and reliable instruments for identifying factors influencing consumption patterns among schoolchildren
- To determine the consumption levels of fruits and vegetables among schoolchildren and their parents in participating countries and in various subgroups (such as gender, socio-economic groups and cultural background)

**Design, implementation and evaluation (process, impact and efficacy) of the intervention programme**
- To determine factors influencing the consumption of fruits and vegetables among schoolchildren in participating countries and in various subgroups (such as gender, socio-economic groups and cultural background)
- To determine cross-national differences in fruit and vegetable consumption among children and their parents, as well as determinants of fruit and vegetable consumption among children
- To determine the local, regional and national policies and organizational structures (including school meals) related to fruit and vegetable consumption

See the Pro Children Project website for more information: [http://www.prochildren.org](http://www.prochildren.org)
Support: The Pro Children project started April 1, 2002 for duration of 48 months, financed by the European Commission Research Directorate General (Contract no. QLK1-CT-2001-00547)

Ten research organisations from nine European countries were involved:

1. University of Oslo, Norway
2. Unidad de Nutricion Comunitaria, Spain
3. Landspitali University Hospital, Iceland
4. University of Copenhagen, Denmark
5. Universidade do Porto, Portugal
6. University of Vienna, Austria
7. Royal Veterinary and Agricultural University, Denmark
8. Erasmus Medical Centre Rotterdam, Netherlands
9. Karolinska Institutet, Sweden
10. Ghent University, Belgium

Trigger: The project was initiated by Knut-Inge Klepp in collaboration with Johannes Brug, both based at Universities. There was a scientific basis to start the project. Similar project were available in the USA but not yet in Europe. Moreover, up to date data on consumption levels of fruit and vegetables among schoolchildren was not available. In order to develop an evidence based intervention, there was the need to investigate consumption levels and its determinants.

Targeted Communities: The intervention developed within the whole project was implemented at primary schools, and was not specifically developed to target children from low SES families. In the Netherlands, however, the intervention was implemented at schools in Rotterdam, one of the major cities and with a high proportion of non-Western immigrant children (about 50%). The school was choosen as the location of intervention because all children can be reached, also those who are normally hard to reach, such as children from low SES families.

Evaluation: The project has already been evaluated and has been published [21].

The programme has proven to be effective, at least at the shorter term, after one year into the intervention (see publication). After two years the intervention was only effective in Norway, where the intervention seems to be best implemented. The intervention was most intensive during the first year, when children were not only provided with free fruit and vegetables but also were involved in class activities such as taste testing and homework assignments. During the first year parents were also involved by means of parent meetings, newsletters and homework assignments.

Additional analyses showed children’s appreciation and parental involvement were important mediators of the intervention [22].

No subgroup analyses have been conducted to see whether children from low SES families improved more or less compared to children from high SES families. Furthermore, no health conditions were measures and it could therefore not be examined whether the intervention improved the health condition of the children.

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Health Behaviour in School-aged Children (HBSC) is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study aims to gain new insight into, and increase our understanding of young people's health and well-being, health behaviours and their social context.

Research into children's health and health behaviour and the factors that influence them is essential for the development of effective health education and health promotion policy, programmes and practice targeted at young people.

It is important that young people's health is considered in its broadest sense, encompassing physical, social and emotional wellbeing. Health should be viewed as a resource for everyday living, and not just the absence of disease.

Therefore, research into children's health needs to consider the positive aspects of health, as well as risk factors for future ill health and disease. Family, school and peer settings and relationships need to be explored, as does the socio-economic environment in which young people grow up, if we are to understand fully the patterns of health and health behaviour found in the adolescent population.

**Aim:** As well as aiming to increase understanding of young people's health, the findings from the HBSC surveys are used to inform and influence health promotion and health education policy and practice at national and international levels.

Its objectives are:

- to initiate and sustain national and international research on health behaviour, health and well being and their social contexts in school-aged children
- to contribute to theoretical, conceptual, and methodological development in the said area of research
- to contribute to the knowledge base in the said research area
- to monitor and to compare health and health behaviour and social contexts of school-aged children in member countries through the collection of relevant data
- to disseminate findings to the relevant audiences including researchers, health and education policy makers, health promotion practitioners, teachers, parents and young people
- to develop partnerships with relevant external agencies in relation to adolescent health to support the development of health promotion with school-aged children
- to promote and support the establishment of national expertise on health behaviour and on the social context of health in school-aged children
- to establish and strengthen a multi-disciplinary international network of experts in this field
- to provide an international source of expertise and intelligence on adolescent health for public health and health education

There are now 43 participating countries and regions. At present, membership of HBSC is restricted to countries and states within the WHO European region. Each country/region is represented by a Principal Investigator (PI) and national research team.

The first cross-national survey was conducted in 1983/84, the second in 1985/86 and since then data collection has been carried out every four years using a common research protocol. The most recent survey, the seventh in the series, was conducted in 2005/06.

http://www.hbsc.org
HBSC is a school-based survey with data collected through self-completion questionnaires administered in the classroom. Fieldwork for each cross-national survey is carried out over a period of around seven to eight months, from October to May of the following year. This reflects the sampling strategy used in each country in order to achieve the mean ages of 11.5, 13.5 and 15.5.

The HBSC survey instrument is a standard questionnaire developed by the international research network and used by all participating countries. The HBSC Research Network comprises member country Principal Investigators and their research teams. There are currently over 250 individual researchers in the network from a range of disciplines.

Each survey questionnaire contains a core set of questions looking at the following:

- **Social and developmental contexts**: demographics and maturation, social background (family structure, socio-economic status), family and peer relationships, school environment
- **Health behaviours**: physical activity, eating and dieting, smoking, alcohol use, cannabis use, sexual behaviour, violence and bullying, injuries
- **Health and well-being**: symptoms, life satisfaction, self-reported health, Body Mass Index, body image

Many countries also include additional items in their national questionnaire that are of particular interest on a national level.

The data collected in each country is sent to the HBSC Data Bank at the University of Bergen, Norway. It is then cleaned and compiled into an international data file by the Norwegian Social Science Data Services (NSD) under the guidance of the study's Data Bank Manager.

When all national data has been received and accepted according to the Protocol, the files are merged and the combined data file is made available to the Principal Investigators of each participating country.

The international data file is available for use by member country teams for a period of three years, after which time the data is available for external use by agreement with the International Coordinator and the Principal Investigators.

The international standard questionnaire enables the collection of common data across all participating countries and thus enables the quantification of patterns of key health behaviours, health indicators and contextual variables. These data allow cross-national comparisons to be made and, with successive surveys, trend data is gathered and may be examined at both the national and cross-national level.

Data analysis is carried out by members of the research network working individually and in topic focus groups.

The study encompasses school systems, embraces many cultures and languages (within and between countries). Every effort is made to standardise the methods employed across countries in order to achieve the best possible comparable data that a cross-national survey will allow.

**Support:** Each member country needs to secure national funding to carry out the surveys and to contribute to the management and development of the international study.

NHS Health Scotland is providing £250,000 per year to enable the International Coordination to take place. The funding has been provided for already 10 years at approximately that level, and will continue for a further three years from October 2009 onwards.

The Child and Adolescent Health Research Unit (CAHRU), University of Edinburgh, is currently the International Coordinating Centre (ICC) of HBSC.
Collaboration with the study's primary partner, the World Health Organization Regional Office for Europe creates opportunities for, and facilitates, the wide dissemination and utilisation of HBSC research findings. The main outputs of this collaboration are the publication of international reports by the Copenhagen Office and the WHO/HBSC Forum series in collaboration with the European Office for Investment for Health & Development in Venice. The goal of the WHO/HBSC Forum series is to bring policy-makers, practitioners and researchers together to compare and learn from experiences in addressing the socio-economic determinants of adolescent health.

**Trigger:** HBSC was initiated in 1982 by researchers from three countries and shortly afterwards the project was adopted by the World Health Organization as a WHO collaborative study.

**Targeted Communities:** The target population of the HBSC study is young people attending school, aged between 11 and 15 years old. These age groups represent the onset of adolescence, the challenge of physical and emotional changes, and the middle years when important life and career decisions are beginning to be made.

The survey is carried out on a nationally representative sample in each participating country. The sample consists of a minimum of 1500 from school years 7 (11 year olds), 9 (13 year olds) and 11 (15 year olds) providing a sample size of approximately 4500 from each participating country.

**Evaluation:** HBSC provides intelligence for the development and evaluation of public health policy and practice at national, sub-national and international levels through the WHO/HBSC forum series. The WHO/HBSC Forum series is a platform designed to facilitate the translation of evidence into action. Forum processes convene researchers, policy-makers and practitioners from across Europe to analyse data, review policies and interventions, and identify lessons learned to improve the health of adolescents through actions that address the social contexts that influence their health. Each Forum process consists of case studies produced by interdisciplinary teams in countries and regions, cross-country evidence reviews, a European consultation, an outcomes statement within a final publication, and a Web-based knowledge platform. In addition to emphasizing the translation of research into action, the Forum series focuses on increasing knowledge in order to scale up inter-sectoral policies and interventions; reduce health inequities; and involve young people in the design, implementation and evaluation of policies and interventions.

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The full title of the project is: the EuropeaN Energy balance Research to prevent excessive weight Gain among Youth: Theory and evidence-based development and validation of an intervention scheme to promote healthy nutrition and physical activity. The ENERGY Project started on the 1st of February 2009.

The ENERGY Project will carry out multidisciplinary analysis of impact and utility of financial and non-financial incentive schemes on extrinsic and intrinsic factors determining healthy behaviour in children and adolescents. ENERGY will further examine the influence of existing schemes on different populations, settings, and purposes and a new intervention scheme will be developed according to theory and evidence-based methods and validated for improved capacity to encourage and sustain the adoption of healthy behaviours.

**Aim:** The overall aim of the ENERGY Study is the development of a new theory- and evidence-based multi component intervention scheme ready to be implemented across Europe promoting the adoption or continuation of health behaviours that contribute to a healthy energy balance. We expect to develop an intervention scheme that is both school-based and family involved, and aimed at the age group of 10-12 year olds, in the transition between childhood and adolescence.

**Support:** The project is funded by the European Commission (FP7-HEALTH-2007-B).

Parties involved are (1) the VU University Medical Center – VUmc Netherlands, (2) the University of Ghent – Ugent Belgium, (3) the University of Oslo – UiO Norway, (4) the University of Agder - UiA Norway, (5) the University of Teesside - Tees UK, (6) the Federal Research Centre for Nutrition and Food - BfEL Germany, (7) the University of Copenhagen - KU Denmark, (8) the University of Zaragoza – UniZar Spain, (9) the Harokopio University of Athens -HUA Greece, (10) the International Taskforce on Obesity – IASO- IOTF UK, (11) the Slovenian Heart Foundation –SHF Slovenia, (12) the University of Pecs – PTE Hungary, the (13) World Health Organisation Europe – WHO/ EURO Denmark and (14) the Deakin University - Deakin Australia.

**Trigger:** The project was initiated by the parties mentioned above.

**Targeted Communities:** ENERGY targets:
- 10-12-year olds;
- Schools; and
- Family environments.

The multi component school-based intervention will be tailored to subjects from different socio-economic backgrounds building upon systematic inventories of existing scientific evidence. The moderating effects of socio-economic status are specifically examined and adapt the intervention accordingly our findings.

**Evaluation:** Not yet applicable.

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2.2 Overall European population

2.2.1 Policy Development

The central objective of the HOPE project – Health promotion through Obesity Prevention across Europe - is to support and advance the development of policies effective for the prevention of overweight, obesity and their negative consequences on health and health inequalities. This is achieved by providing estimates of the potential impact of interventions directed at key determinants of obesity in the European Union. This is in line with the central objective of this task and responds to the need to increase and integrate knowledge to inform health promotion and health protection policies at the EU level.

Based on a ‘network of network’, the HOPE project will gather all available evidence to provide an overview of preventive intervention and policy measures, encompassing the life course stages and focusing on the lower socio-economic groups. The enormous variation across Europe in nutrition, physical activity, obesity and environmental determinants will form the basis to assess potential effects of a variety of measures. Furthermore, in the context of current food label agreements, Common Agricultural Policies, transport and urban renewal policies, the EU has a major opportunity to readdress the balance and promote conditions for good health. The development of multi-sector policies has been endorsed in ministerial meetings of the WHO Regional Committee for Europe and in the Action Plan for Food and Nutrition Policy, adopted in 2000. Through the development of scenarios on the impact of interventions, the HOPE project will raise awareness and motivate stakeholders in both the private and public arena.

During the project, the following *proximal determinants* will be studied:

Nutrition and physical activity lifestyle factors, with a specific emphasis on more specific obesogenic or obeso-preventive behaviours such as:

- Intake of high fat, sugar-rich and other energy-dense foods
- Intake of fruit and vegetables and other fibre-rich foods
- Intake of sugar-sweetened drinks
- Meal patterns, i.e. breakfast habits, meal frequency and frequency of snack food consumption
- Transport physical activities
- Leisure time physical activities
- Sport activities
- Sedentary behaviours, i.e. TV viewing

And the following *distal determinants* will be studied:

- Socio-economic factors: educational level, employment status, wealth and household income
- Macro-environmental factors, with a specific focus on the policy and informational environmental
- Factors at the European, Member State and/or regional level
- Micro-environmental factors, with a specific focus on physical, social-cultural, and political environmental factors at the family, school and workplace level.

This Project was set up for several reasons. Firstly, few studies have focused on the distal obesogenic physical, social-cultural, financial and political environmental factors that drive obesogenic behaviours. Furthermore, no co-ordination action has integrated knowledge and translated this into
recommendations for policies and interventions at key age groups, i.e., early childhood, adolescence and early adulthood. There is limited exchange between EU Member States on strategies and methodologies. As a result, learning effects have been modest, and an EU-wide comprehensive inventory of preventive interventions aimed at broad implementation is lacking. Furthermore, ongoing interventions have not been evaluated extensively, and their impact on the lower socio-economic groups has not been established or published internationally. Although some reviews on the effectiveness of educational campaigns and policy measures for nutrition and physical activity have been carried out, these are outdated or restricted to certain groups. Finally, no attempts have been made to assess the potential impact of effective interventions to tackle environmental determinants on the European population through the development of scenarios.

**Aim:** The HOPE project aims to support and advance the development and implementation of systematic, evidence-based European, national and regional policies effective for the prevention of obesity and its negative consequences on health and health inequalities.

HOPE-project wants to bring all the scientific knowledge on overweight, obesity and their determinants together and use the expertise of researchers all over Europe.

The project specifically aims:

1. To integrate scientific knowledge from ongoing scientific efforts on nutrition, physical activity, overweight and obesity, and health inequalities, and to translate it into policy recommendations for obesity prevention across Europe.
2. To improve understanding of obesity and lifestyle factors by estimating the prevalence and trends of overweight and obesity, physical activity and nutrition patterns among infants, adolescents and adults.

3. To assess the impact of macro-policy and micro-level environmental factors at the family, school and work place on obesity and on preventive nutrition and physical activity behaviours across Member States.
4. To improve understanding of obesity-related health inequalities by assessing socio-economic differences in physical activity, nutrition, overweight and obesity and their determinants across Member States.
5. To assess the potential to tackle these determinants by conducting systematic reviews and inventories of evidence-based interventions and policies across Europe, with an emphasis on the school and workplace settings, and on the lower socio-economic groups.
6. To estimate the future burden and impact of obesity on future trends in morbidity, mortality and health inequalities, through the development of scenarios of the impact of implementing plausible effective policies and interventions among children, adolescents and adults across the European Union.

**Support:** The HOPE project consortium consists of a multidisciplinary team of specialists in the fields of obesity, epidemiology, nutrition, physical activity, public health and health promotion from 14 countries. The project is financial supported by the European Union.

The project is coordinated by the Department of Public Health of the Erasmus University Medical Centre assisted by the International Obesity task Force and the International Association of the Study of Obesity.

**Trigger:** The prevalence of overweight and obesity in Europe has been steadily increasing, with rates doubling during recent decades in several countries. An increasing number of the Member States have obesity levels (BMI>30) exceeding 20% in the adult population, and more than 50% of the total European adult population is overweight (BMI>25). Up to 20% of children in several Member States are overweight. The number of overweight children is estimated to be 22 million in 2006, increasing by over one million per year. This includes over 5 million children who are obese, a figure which is rising annually by over 300,000.
Targeted Communities: The overall target community is the European population, but based on a ‘network of networks’, the HOPE project will gather all available evidence to provide an overview of preventive intervention and policy measures, encompassing the life course stages and focusing on the lower socio-economic groups.

Sub target communities are: early childhood, adolescents (10-18 years), young adults and lower socio-economic groups:

- **WP3** is devoted to identifying the major family-environmental determinants of obesity in early childhood and to identify and recommend policies and interventions that can prevent the development of obesity at the very early stages of life;
- The overall aim of **WP4** is to integrate knowledge on the determinants of nutrition, physical activity and obesity among adolescents, and to identify entry-points for effective policies and interventions to prevent obesity at this early stage of life;
- The aim of **WP 5** is to review and to explore the influence of work-related and neighbourhood environmental factors on obesogenic nutrition and physical activity among young adults;
- **WP7** aims to assess socio-economic differences in the progression of the obesity epidemic; and
- **WP 6, 8 and 9** are devoted to systematic reviews of evidence on the effectiveness of interventions and policies for obesity prevention with a focus on the sub target communities, mentioned above.

Evaluation: The project is not yet evaluated.

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EURO-PREVOB is a European Coordination Action linking science and policy-making to tackle obesity and inequalities in obesity in Europe. The project promotes collaboration across existing networks, to address the social and economic determinants of obesity, including developments that recognise the specificities of sub-regional groupings of countries. EURO-PREVOB started in April 2007 and is set to run until March 2010.

**Aim:** The project aims to (1) improve the understanding of the broad determinants of, and inequalities in, obesity, (2) identify policy initiatives that can impact positively on the determinants of obesity, (3) develop and pilot tools to assist policy analysis, and (4) draw upon the project outputs to propose recommendations contributing to efforts at preventing obesity in Europe. The programme of work integrates complementary activities, such as producing reviews of the literature, conducting policy analysis activities, and disseminating information through consultations and other forms of policy engagement.

**Support:** EURO-PREVOB is funded by the European Commission’s 6th Framework Programme and involves 13 participants from 10 European countries (Bosnia and Herzegovina, the Czech Republic, Denmark, France, Italy, Latvia, Slovenia, Switzerland, Turkey, and the United Kingdom) and from a variety of key disciplines, including nutrition, physical activity research, public health, epidemiology, economics, and health policy.

**Trigger:** EURO-PREVOB was developed in response to a call from the European Commission. The project specifically responds to the fact that current scientific knowledge remains inadequately integrated into health protection policies, so that action on nutrition and physical activity fails to tackle obesity and especially inequalities in obesity in Europe. This coordination action project integrates, at a European level, resources and expertise within and beyond the area of public health nutrition and physical activity.

**Targeted Communities:** Addressing socio-economic inequalities in obesity, and specifically creating the opportunities for making healthy food choices and for physical activity, are central to the aims of EURO-PREVOB. A key premise of the project is that individuals (and their intrinsic risk of obesity) are influenced by the environments in which they live. Thus one element of EURO-PREVOB is to examine socio-economic differentials in the environmental determinants of obesity, specifically by piloting a Policy Analysis Tool in five sub-regions of Europe.

The Policy Analysis Tool has two main components: (1) The Policy Checklist: a questionnaire on the status of national policy on four thematic areas (food environment, built environment, maternal and young child health services, and schools) with explicit questions on whether socio-economic inequalities are addressed in each policy area; and (2) the Community Questionnaire: a rapid assessment of environmental indicators at the community level divided into two thematic sections (food environment and built environment), designed to be used in areas representing a spectrum of socio-economic levels. The Policy Analysis Tool was piloted in five countries from different sub-regions of Europe (in brackets are the cities where the Community Questionnaire was tested): (1) Czech Republic for Central and Eastern Europe (Brno); (2) Latvia for the Nordic-Baltic Region (Riga); (3) Turkey for Southern Europe (Ankara); (4) Bosnia and Herzegovina for South Eastern Europe (Sarajevo); and (5) France for Western Europe (Marseille).

In the last year of the project, socio-economic inequalities in obesity will be integrated in a set of recommendations for obesity prevention in Europe.

**Evaluation:** Evaluation mechanisms have been developed and included into all parts of EURO-PREVOB. Monitoring is integrated within the project by way of an Advisory Board that comprises a group of experts in obesity and related fields.
The Advisory Board is mandated to ensure that the project proceeds in a satisfactory manner and in a way that responds to the needs of policy-makers and stakeholder groups.

Evaluation was an intrinsic part of the development and testing of the Policy Analysis Tool described above. The first version of the tool was reviewed by a group of experts and stakeholders in April 2008. The revised tool was then piloted in five countries. Process evaluation questionnaires have been developed to assess the applicability and usefulness of the tool during the pilot tests, and to document its actual implementation. The information gathered will lead to a better understanding of the strengths and weaknesses of the tool, including whether it effectively captured the policy and environmental factors that could influence food choices and physical activity between countries, and among areas of different socio-economic levels within countries. The results of the pilot testing of the tool, including process evaluation, and other project outputs will be published as reports made available on the project website and peer-reviewed articles.

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The scope of the project TEENAGE is the prevention of socio-economic inequalities in health behaviour in adolescents in Europe by collecting and disseminating evidence throughout Europe. The project aims to identify and evaluate the effectiveness of comprehensive policy approaches to address health inequalities. In addition the project wants to identify, evaluate and disseminate good practice on including a social determinants focus in strategies that address determinants of socio-economic inequalities such as nutrition and physical activity, tobacco, drugs, and alcohol.

The TEENAGE consortium brings together expertise in the field of health inequalities and of health promotion. It consists of a variety of experts in the fields of socio-economic inequalities in health, public health, epidemiology, nutrition, physical activity, tobacco, drugs and alcohol from five different European countries: the Netherlands, Belgium, Norway, United Kingdom and Italy and several collaborating institutes from other countries.

Many ‘modern’ health promotion interventions are currently conducted, including use of the Internet, and changes in the environment. Knowledge of the effectiveness and the transferability throughout Europe of such interventions can contribute to the prevention of socio-economic inequalities in health behaviour by formulating policy recommendations.

The major innovations of TEENAGE are:

- The project brings together expertise in the field of health inequalities and of health promotion;
- The project focuses on the prevention of socio-economic inequalities in health behaviours instead of the reduction in inequalities;
- The project will assess whether interventions are effective in host countries and if interventions can be transferred to other countries;
- The project will develop and apply an instrument on the basis of which the applicability of interventions can be assessed. This instrument enables to extend the formulation of policy to countries without ongoing interventions in different European regions;
- The project will apply state-of the-art statistical techniques to re-analyse interventions, even if this was not done so in original analyses. It will therefore generate important new evidence of the evaluation of public health interventions and interventions to prevent socio-economic inequalities in health, directly relevant for policy makers; and
- The project develops training materials for the prevention of socio-economic inequalities in health, which are currently unavailable.

The work to be done within the TEENAGE project is divided into 9 so-called work packages (WP) and will be conducted under the leading roll of Erasmus MC, University Rotterdam (the Netherlands).

1. **WP1**: Coordination TEENAGE project; the aim of this work package is to support the overall running of the project through the co-ordination of activities of all work packages and the construction of a management information system. This work package will comprise the co-ordination task to promote and ensure integrated and timely progress of the project and reporting to the EU. It will carry out the administrative tasks and will be responsible for the financial and organizational management of the project.

2. **WP2**: Dissemination results TEENAGE; the main objective will be to disseminate all output/deliverables of the project. This will be mainly done in a form that can help policy makers at the European, national and local level to obtain the information needed to formulate policies.

3. **WP3**: Evaluation TEENAGE project; this WP aims to evaluate the project, both in terms of process outcomes as well as project outcomes.
4. **WP4:** *The prevention of SES inequalities in physical inactivity in adolescence*; the aim of this work package is to develop evidence of effectiveness of interventions and policies to prevent physical inactivity in European adolescents (11-18 years).

5. **WP5:** *The prevention of SES inequalities in poor diet in adolescence*; the aim of this work package is to develop evidence of effectiveness of interventions and policies to prevent poor diet in European adolescents (11-18 years).

6. **WP6:** *Prevention of SES inequalities in smoking uptake in adolescence*; the aim of this work package is to develop evidence of effectiveness of interventions and policies to prevent smoking in European adolescents (11-18 years).

7. **WP7:** *The prevention of SES inequalities in alcohol use in adolescents in Europe*; the aim of this work package is to develop evidence of effectiveness of interventions and policies to prevent alcohol consumption in European adolescents (11-18 years).

8. **WP8:** *Assessing the transferability of evidence from "source" countries to other countries*; work package 8 will assess the transferability of results of interventions from 'source' countries (the countries in which the intervention was evaluated) to 5 other countries. Those 5 other countries, the 'target' countries will represent different regions in the EU (North, West, South, East).

9. **WP9:** *Integrating evidence of effectiveness and knowledge of transferability into policy recommendations*; work package 9 aims to synthesize the evidence obtained in the specific Work packages 4-7 and the knowledge on the transferability obtained in WP 8 and to translate this into policy recommendations.

**Aim:** The general aim of TEENAGE is to generate and disseminate evidence on the effective approaches for prevention of socio-economic inequalities in health behaviour among adolescents. The evidence will be relevant to the European level as well as national and local levels.

**Strategic objectives include:**

- Development of evidence on the effectiveness of interventions to prevent physical inactivity, poor diet, smoking, and alcohol consumption in adolescents in lower socio-economic groups across Europe.
- Assessment of the transferability of effective interventions in lower socio-economic groups from 'source' countries to other countries throughout Europe.
- Development of policy recommendations for the prevention of socio-economic inequalities in these health behaviours in adolescents in lower socio-economic groups in Europe.
- Dissemination of the results and development of a European clearing-house on the prevention of the inequalities in unhealthy behaviour in adolescents in Europe.

**Support:** The project is subsidized by the Public Health programme from the European Commission.

The TEENAGE consortium brings together expertise in the fields of health inequalities and health promotion and consists of a variety of experts in the fields of socio-economic inequalities in health, public health, epidemiology, nutrition, physical activity, tobacco, drugs and alcohol from five different European countries: the Netherlands, Belgium, Norway, United Kingdom and Italy, and several collaborating institutes from other countries.

**Trigger:** Previous and ongoing projects show persistent socio-economic inequalities in health in European countries. Smoking, physical inactivity, poor diet and alcohol consumption contribute at least 30-50% to socio-economic inequalities in health. These behaviours mainly develop in adolescence. A crucial entry point for policies to reduce inequalities in health is the prevention of unhealthy behaviour in adolescents in lower socio-economic groups.
Many ‘modern’ health promotion interventions are currently conducted, including use of the Internet, and changes in the environment. Knowledge of the effectiveness and the transferability throughout Europe of such interventions can contribute to the prevention of socio-economic inequalities in health behaviour by formulating policy recommendations.

**Targeted Communities:** Because behaviours developed in adolescence are largely maintained in adulthood, preventing unhealthy behaviour in adolescents in lower socio-economic groups is a crucial strategy for the prevention of socio-economic inequalities in health in adulthood.

In the field of health promotion, the importance of preventing disease early in life is well recognized. It has resulted in a substantial amount of research how to prevent unhealthy behaviour in the critical period of adolescence. The complexity of prevention is well known. Results of traditional health education (defined as "planned learning experiences to facilitate voluntary change in behaviour") are at most effective on the short term.

The transition to health promotion (defined as "the combination of educational and environmental supports for actions and conditions of living conducive to health"), has resulted in a stronger attention for environmental barriers and opportunities for health behaviours. Current health promotion efforts however, do not specifically focus on adolescents with the highest probability of unhealthy behaviour in adulthood - those in lower socio-economic groups.

**Evaluation:** The project is not yet evaluated.

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2.2.2 Research Studies

The HELENA project (Healthy Lifestyle in Europe by Nutrition in Adolescents) includes cross-sectional, crossover and pilot community intervention multi-centre studies, as an integrated approach. The project started May 1st, 2005 and for the cross-sectional study, there was a pilot study in April-May 2006. The project will provide information about the nutritional status of the European adolescents:

1. dietary intake, nutrition knowledge and eating attitudes;
2. food choices and preferences
3. body composition;
4. plasma lipids and metabolic profile;
5. vitamin status;
6. immune function related to nutritional status;
7. physical activity and fitness; and
8. genotype (to analyse gene-nutrient and gene-environment interactions)

Both scientific and technological objectives should result in reliable and comparable data of a representative sample of European adolescents, concerning: foods and nutrients intake, food choices and preferences, obesity prevalence, dislipidemia, insulin resistance, vitamin and minerals status, immunological markers for subclinical malnutrition, physical activity and fitness patterns, and variations of the nucleotide sequence in selected genes. This will contribute to understand why health-related messages are not being as effective as expected in the adolescent population. A realistic intervention strategy was proposed in order to achieve the goals of understanding and effectively enhancing nutritional and lifestyle habits of adolescents in Europe.

Aim: The main objective of the project is to obtain reliable and comparable data of a representative sample of European adolescents. This will contribute to understand why health-related messages are not being as effective as expected in the adolescent population. The requirements for health promoting foods were also identified, and three sensory acceptable products for adolescents were developed.

Support: The project is supported by the EU 6th Framework programme. Partners involved are: (1) Universidad de Zaragoza (Spain), (2) Consejo Superior de Investigaciones Científicas (Spain), (3) Université de Lille 2 (France), (4) Research Institute of Child Nutrition Dortmund (Germany), (5) Pécsi Tudományegyetem
(University of Pécs) (Hungary), (6) University of Crete School of Medicine (Greece), (7) Rheinische Friedrich Wilhelms Universität (Germany), (8) University of Granada (Spain), (9) Istituto Nazionale di Ricerca per Glì Alimenti e la Nutrizione (Italy), (10) University of Napoli "Federico II" Dept of Food Science (Italy), (11) Ghent University (Belgium), (12) University of Vienna (Austria), (13) Harokopio University (Greece), (14) Institut Pasteur de Lille (France), (15) Karolinska Institutet (Sweden), (16) Asociación de Investigación de la Industria Agroalimentaria (Spain), (17) Campden & Chorleywood Food Research Association (United Kingdom), (18) SIK - Institutet foer livsmedel och bioteknik (Sweden), (19) Meurice Recherche & Developpement asbl (Belgium), (20) Campden & Chorleywood Food Development Institute (Hungary), (21) Productos Aditivos SA (Spain), (22) Carnicas Serrano SL (Spain), (23) Cederroth International AB (Sweden), (24) Cerealia R&D AB (Sweden), (25) EUFIC (Belgium), (26) Universidad Politécnica de Madrid (Spain).

**Trigger:** A school-based lifestyle education intervention was performed in 6 European cities: Ghent (Belgium), Vienna (Austria), Stockholm (Sweden), Dortmund (Germany), Athens (Greece), and Heraklion (Greece), without any specific reason.

**Targeted Communities:** The HELENA intervention was a feasibility study, in order to try applying it in further intervention studies in Europe. Health inequalities were not taken into account for the feasibility study, but it will be considered in further studies.

**Evaluation:** There are no published reports describing the intervention outcome. Two papers will be submitted soon. The intervention seemed effective in terms of physical activity behaviour. No assessment of obesity outcomes.

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Figure 14: HELENA Study

Source: Luis Moreno, HELENA Study
The integrated approach adopted here represents a significant step forwards as compared to previous projects in this field: the quantitative analyses of health indicators (objective 1) will show what the main entry-points for tackling health inequalities in the participating countries are, while a wide range of evidence on effectiveness (objective 2) will provide guidance as to the policies and interventions that can help to address these entry-points.

**Objective 1: Health inequalities indicators and benchmarking data.**

While preparing this proposal we have made a preliminary inventory of availability of data on socio-economic inequalities in health in the participating countries. Data on inequalities in mortality are available in at least 20 countries (including 7 applicant countries). Data on inequalities in self-reported morbidity are available in at least 24 countries (including 9 applicant countries). We are therefore confident that this project will provide a uniquely comprehensive overview of health inequalities in Europe that will be used not only to ‘benchmark’ each individual country but also to make interesting cross-national comparisons, including between current EU member and applicant countries. This project will also be a significant step forwards in terms of understanding the causes of health inequalities. It will take advantage from existing variations between European countries to study the impact of three groups of factors: health-related behaviours, health care utilization, and labour market and welfare conditions. Availability of data on inequalities in these determinants has not yet been assessed in detail, but it is likely that each of the in-depth analyses of the impact of determinants on health inequalities will cover at least 10 countries, and can therefore be expected to advance our understanding of the causes of health inequalities considerably.

**Objective 2: Evidence on effectiveness of policies and interventions.**

Evidence-based policy-making in the field of health inequalities is severely hampered by lack of good evidence on effectiveness of policies and interventions. Because this has now been recognized widely, many new initiatives in this field throughout Europe are being accompanied by evaluation studies of various designs. Because of the complexity of the task, and the practical barriers for conducting evaluation studies, no single country has the capacity to build a comprehensive evidence-base for tackling health inequalities on its own. It is therefore essential to create opportunities for mutual learning from each other’s evaluation studies. This requires the availability of explicit criteria for assessing their internal validity (absence of bias in measuring effect) and external validity (generalisability of effect from one setting to the other). Such criteria are currently not available, will therefore be developed in this project, and will be made available in the form of a check-list to the international community. The criteria will subsequently be applied to at least 5 examples each of recent evaluations of policies and interventions in 3 areas: health-related behaviours, health care, and labour market and welfare conditions. Examples will be selected from across Europe on the basis of the opportunities they provide for methodological and substantive learning.

Our previous work has described the necessary data for monitoring health inequalities on the basis of mortality follow-up data linked to national population censuses, and on the basis of morbidity data as measured in national health or multipurpose interviews. These methods have been applied extensively in EU member countries, and have enabled interesting cross-country comparisons of the size and pattern of health inequalities. These comparisons have not only provided benchmarking data, but also new insights into the explanation of health inequalities (showing, for example, the importance of smoking as a determinant of health inequalities in the North of Europe). These methods will now be extended in several ways: inclusion of applicant countries (a preliminary inventory of data shows that at least 9 of these countries have such data) and
measurement of inequalities in health determinants (data on a number of risk factors by socio-economic status are available in most countries participating in this project). This will not only provide the EU with a great amount of new and relevant data, but will also provide researchers and policy-makers with exciting new opportunities for comparative research. Examples of such comparisons, based on the same methodology as our previous work, will be carried out during this project.

With support from the EC we have previously written the first international overview of evidence relating to the effectiveness of policies and interventions to tackle health inequalities. This analysis was based on a preliminary set of criteria for assessing this evidence, and identified a number of ‘promising’ new approaches that have been very helpful to policy-makers. The current proposal aims to take this one important step further by developing a set of explicit criteria for assessing internal validity and external validity of evaluation studies. Criteria for assessing internal validity will be developed on the basis of rules used by the Cochrane collaboration, but these rules will have to be modified extensively because of problems in the application of Randomized Controlled Trials in this field. In developing these criteria we will build upon the work of the Cochrane non-randomized studies group and of the Campbell Collaboration, a social sciences initiative similar to the Cochrane Collaboration. Criteria for assessing external validity will relate to general characteristics of the intervention and the population in which it has been evaluated, but also to determinants involved in the causation of health inequalities, to on-going policies and interventions against these determinants, and to possibilities for implementation of the new policy or intervention.

Aim: The over-all aim of this project is to facilitate such mutual learning by collecting and analysing information from different European countries that will help policy-makers at the European and national level to develop rational strategies for tackling socio-economic inequalities in health. The specific objectives are:

1. To develop and collect health inequalities indicators, and to provide benchmarking data on inequalities in health and health determinants to participating countries;
2. To assess evidence on the effectiveness of policies and interventions to tackle the determinants of health inequalities, and to make recommendations on strategies for reducing health inequalities in participating countries;
3. To disseminate the results, and to develop a proposal for a permanent European clearing house on tackling health inequalities.

Support: The Eurothine project is funded by the public health program of the SANCO Directorate General of the European Commission. This project will be carried out by a consortium of 3 existing networks:

- European Working Group on socio-economic inequalities in morbidity and mortality (EWGSimm)
- European Network on interventions and policies to reduce inequalities in health (ENiprih)
- Barcelona Inequalities Network (also known as the European Research Network on social inequalities and health (ERNsih)).

The work will be organized as follows:

- The co-ordinating centre at Erasmus MC, University Medical Center Rotterdam, the Netherlands, will be responsible for central co-ordination, liaising with the European Commission, and the 3 generic work-packages.
- Collaborating centres in Estonia, Belgium, Germany, Spain, the United Kingdom, Italy and the Netherlands will be responsible for 8 specific work-packages.
- Around 50 researchers and policy-makers from 25 European countries will be responsible for collection of information from their own country. Results will be discussed at plenary network meetings to enable all members to participate in the interpretation of the results.
3. Projects at National Level

This chapter describes what health promotion actions have currently been put in place by countries that contributed to this report at a national level. The information was collected from the following sources:

- A report published by EuroHealthNet in 2006 (The contribution of Health Promotion to address obesity in the European Union) [2]. This document reported on general health promotion measures but did not study whether or not lower socio-economic groups were included as special risk groups. Results were therefore reviewed for relevant data.

- A report published by the World Health organisation (WHO) in 2007 (Nutrition, physical activity and the prevention of obesity. Policy developments in the WHO European Region) [23]. This document contains information on national policy developments and examples of implemented and ongoing programmes at the national and local levels in 48 countries of the WHO European Region. Again, the data described was studied for examples that specifically target disadvantaged communities.

- EuroHealthNet members were asked to send in information on relevant developments since 2006.

The obesity prevention measures within countries are subdivided over three paragraphs:

- **National Strategy**: This section includes descriptions of national action plans, implemented health policies that are relevant to this report, and other national legislative strategies (e.g. also the start of an obesity council)

- **National Support**: This paragraph describes national support organisations such as funds or coordination groups that provide support, guidance and coordination to smaller initiatives. Many of the local projects described in the next chapter will refer to these national support structures.

- **National Programmes**: At last, programmes and campaigns that run at national level and aim to counteract obesity specifically among disadvantaged groups, or define such communities as a special risk group, are described.

This chapter does not aim to provide a full picture of all running health promotion measures within countries, but it is a starting point describing the situation of obesity in relation to health equity at national level. Please note that only those countries are described that contributed to this report. If further information regarding other European countries is requested, please consult the reports published by EuroHealthNet [2] and WHO [23].
Austria

**National Strategy:** In Austria, there is no overall National Obesity Strategy. However, the Austrian Strategy for Sustainable Development adopted in 2002 (Ministry of Agriculture) can be considered as impacting on obesity. In this report, the importance of targeting different socio-economic groups is being recognised.

**National Support:** The Austrian organisation Fund for a Healthy Austria (Fonds Gesundes Österreich – FGÖ) is a health promoting organisation, founded in 1998, and receives subsidiaries of the ‘Gesundheit Österreich GmbH’ (Health Austria Ltd). The Fund’s major task is to support practical and research projects, structural development, continuous education, networking and information campaigns in the field of health promotion.

Two out of its six key priorities are Exercise and Nutrition. All recent Work programmes have integrated these two key priorities and FGÖ gives financial support to many projects concerning the promotion of healthy nutrition and/or physical activity. FGÖ has been conducting activities to enhance health awareness in these fields through, on the one hand, public information and education campaigns and, on the other hand, project funding. A list of all projects can be found on the FGÖ website (http://www.fgoe.org), and more information about the Fund and the national programmes it’s supporting are listed in the EuroHealthNet and WHO reports.

Thus far, more than €25 million has gone into supporting 542 projects (approved/recommended up to now). The FGÖ support only goes to projects involving total funding of more than €10,000.

**National Programmes:** On national level, there are no campaigns running that aim to counteract obesity specifically among lower socio-economic groups.

Belgium

*(Extra information was provided by the Flemish Institute of Health Promotion and Disease Prevention (VIGeZ) - EuroHealthNet member)*

**National Strategy:** The National Plan for Nutrition and Health 2005 – 2010 (Plan National Nutrition et Santé) was officially launched in March 2005. The plan emphasizes the need to create an environment that stimulates healthy eating habits and physical activity by improving education on food and nutrition and involving a number of stakeholders. The National plan recommends measures such as:

- Leading actions aimed at encouraging everyone but above youngsters to give more importance to physical exercise and to healthy eating habits,
- Organising targeted actions focused on specific groups such as young children, aged people, pregnant woman, teenagers, etc...
- Encouraging the private sector to engage more in reaching the objectives of the National Plan Nutrition and Health,
- Tackling prevention and undernutrition treatment,
- Evaluating eating habits and Belgian people’s lifestyles, through eating surveys,
- Stimulating scientific research devoted to eating behaviours.

**The French Community:** In November 2005, a plan to stimulate healthy eating and physical activity for children was approved and launched (Manger Bouger). The main goal of the French Community Plan is to reduce factors leading to cardiovascular diseases, but it also aims to half the growing incidence of obesity in young people by encouraging them to eat healthier and be more physically active. The message must be comprehensible for every environment affecting children from 0 to 18 years of age: day care, school, outside school and family.

It is based on various communication tools and has been established in accordance with the National Nutrition and Health Plan.
The Flemish Community: A draft action plan on diet and physical activity 2008 – 2015 for Flanders was launched in October 2008 [26]. The ambition behind this action plan is to encourage the entire population of Flanders to be more physically active and to have a more balanced diet. Alongside its proactive attitude the action plan also adopts a problem-based approach; it aims to keep the prevalence of obesity under control.

The ultimate objective of the action plan is to promote balanced eating patterns and adequate physical activity in accordance with the recommendations of the Flemish Food and Physical activity Guide named ‘The active Food triangle’ (figure 15) developed by the Flemish Institute of health Promotion and Disease Preventions (VIGeZ). These recommendations are based on the national nutritional recommendations from the Health Board and the HEPA 2001 recommendations for physical activity. Further input to the Flemish action plan has come from the Nutrition Action Plan 2004.

The Flemish action plan that has now been proposed consists of a set of six strategies, with a consistent focus on educational activities, environmental measures, policy measures and professional development.

- **Strategy 1**: Adequate physical activity and a more balanced diet in the local community.
- **Strategy 2**: Adequate physical activity and a more balanced diet among children and young people from birth to age 18.
- **Strategy 3**: Adequate physical activity and a more balanced diet at school
- **Strategy 4**: Adequate physical activity and a more balanced diet among the working Population
- **Strategy 5**: Improved provision of support to care providers
- **Strategy 6**: To promote adequate physical activity and a more balanced diet via information and communication

The actions included in strategy 1 are clustered within 2 priorities. Priority one aims to ‘provide appropriate resources to local policymakers and organisations working with low-opportunity and/or ethnic cultural minorities, in order to encourage adequate physical activity and balanced diet among social risk groups.’ Thus, the Flemish action plan pays special attention to lower socio-economic groups while aiming to counteract obesity.

![Figure 15: The active food triangle: Recommendations for daily intake of foodstuffs in different categories and daily physical activity, from age 6 onwards. Source: ©VIGeZ (2004)](image)

**National Support:** Several programmes and campaigns are developed by the Flemish Institute of Health Promotion and Disease Prevention (VIGeZ). VIGeZ is an expert centre on the subject of health promotion healthy life styles, warranted by the Flemish authorities to provide government, professional intermediaries and local health networks with general support and the coordination of policy implementation, internal quality assurance, and the development of new
strategies, programmes and materials. While operating as the medium to advocate the Flemish government’s guidelines with respect to health promotion, ViGeZ seeks to guarantee sufficient expertise, quality, feedback and the dissemination of results. A list of all projects can be found on the ViGeZ website (http://www.vigez.be) and most of them are described in the EuroHealthNet document: The contribution of Health Promotion to address obesity in the European Union.

**National Support:** The mission of the King Baudouin Foundation (Koning Boudewijn Stichting) is to help to improve living conditions for the population. In its 1976 Constitution the Foundation is described as “an independent structure that entourages original ideas and sets up new projects.” The Foundation works together with other institutions and foundations in both Belgium and Europe.

The King Baudouin Foundation supports projects and citizens who are committed to create a better society. It focuses on specific themes and is based in Brussels, but also supports projects far beyond the borders of Belgium and Europe. The activity domains are grouped around Poverty & Social Justice, Health, Democracy in Belgium, Democracy in the Balkans, Heritage, Philanthropy, Migration, Development, Leadership, Local engagement and Partnership or exceptional support for projects. Under the activity domain ‘Health’, the foundation supports many projects that are targeting the lower socio-economic communities.

For 2007 the King Baudouin Foundation had an annual budget of approximately 48 million euro. In addition to a large grant from the National Lottery there were donations, legacies and the Funds set up by individuals, associations and companies, Government missions, partnerships and project accounts. More information about this foundation can be found at: http://www.kbs-frb.be.

Since 1998, cooperation exists on supralocal level (regions from 250.000 – 300.000 inhabitants) for the coordination and support of local initiatives in Flanders. Logo’s – an abbreviation for LOkaal GezondheidsOverleg – are local health consultative bodies that work together to promote health and to contribute to the realisation of the Flemish Health Objectives. One of these six targets is to improve physical activity and healthy nutrition. Logo’s are a network of organisations, whereby not only the health sector is involved but also the local authorities, the OCMW’s, and the wealth, social-cultural and educational sectors. OCMW’s (Openbaar Centrum voor Maatschappelijk Welzijn) are Public Centres focusing on a community’s health and wellbeing. Every city or town has its own OCMW.

**National Programmes:** On national level, there are no campaigns running that aim to counteract obesity specifically among lower socio-economic groups.
Bulgaria
(Extra information was provided by the National Centre of Public Health Protection - EuroHealthNet member)

National Strategy: The National Food and Nutrition Action Plan (NFNAP) was launched in December 2004 and adopted by the Council of Ministers in August 2005. It covers the period 2005-2010 and its strategic goal is to improve the health of the Bulgarian population by improving nutrition and the reduction of the risk of food-borne and diet-related chronic diseases [27].

The action plan covers three strategic areas: nutrition, food safety and food security. It aims at a multi-sectoral approach involving the private sector and nongovernmental organizations, and includes activities addressing people of low socio-economic status. Other activities targeting overweight and obesity relate to the development of new standards for the nutritional content, labelling and marketing of foods, incentives to encourage the production and sale of healthier foods, and the training of health professionals.

The action plan describes a significant difference in the availability of food products depending on population income and a lower availability of the majority of foodstuffs in low income households, in households with 6 and more members, those with 3 and more children and households where the head is unemployed is established, comparing to the average availability per capita in the country.

Since 1997, six national surveys have been conducted on the diet and nutritional status of the population older than one year, as well as of specific risk groups. Special software was developed to monitor foods consumed and calculate intake of energy and nutrients at individual and population levels. The results of this survey have been used as a basis for the development of the above mentioned National Food and Nutrition Action Plan.

National Support: Bulgaria is involved in several programmes — most of them being international programmes set up by the WHO. An overview and description can be found in the EuroHealthNet and WHO report [2, 23].

Apart from the campaigns mentioned in these documents, the National Centre of Public Health Protection is currently developing nutrition manuals and recipes collection on healthy nutrition for different age groups (3-6 yrs, 7-19 yrs), and it is developing nutrition standards for foods in school.

National Programmes: At the moment there are no ongoing obesity prevention programmes in Bulgaria that specifically target disadvantaged communities.
Czech Republic

(Extra information was provided by the Ministry of Health of Czech Republic - MZCR)

National Strategy: In 2004, the Minister of Health established the National Council for Obesity as a permanent specialist advisory body to the Ministry of Health. The basic task of the Council is to design and implement the National Action Plan against Obesity. However, to date no action plan focused on the prevention of obesity exists in Czech Republic.

A programme related to obesity is the long-term Programme for Improving the Health Status of the Population in Czech Republic (Health for All in the 21st Century) which was adopted in 2002. It consists of 21 objectives to be reached and some of these targets are focused on obesity [2].

Further details regarding national strategies, and national campaigns and projects can be found in the EuroHealthNet document and the report written by WHO [2,23].

Denmark

(Extra information was provided by the National Board of Health - EuroHealthNet member)

National Strategy: The Danish Public Health Policy of the Government of Denmark: Healthy throughout Life (2002-2010) was adopted in 2002 and addressed diet, physical activity and obesity as risk factors [28]. To ensure regular monitoring and documentation of trends in the health status and health behaviour of the population, a catalogue of indicators was developed. Several initiatives were listed with the aim of increasing the commitment of specific actors. One of these was the creation of a National action plan against obesity.

In March 2003 the Danish National Board of Health launched the Danish National Action Plan against Obesity [29]. Denmark was the first country in Europe to launch such a specific action plan. It presents 66 recommendations specifying actions to be taken at private, community and public sector level. These recommendations aim to target different groups and areas. However, these classifications are based on groups being overweight or obese already or not. The national action plan thus does not target the lower socio-economic groups in a specific matter, but the recommendations in the action plan are however based on the knowledge about the social inequalities in health.

National Support: Since the launch of the action plan in 2003, the National Board of Health has initiated a series of projects covering the period 2005–2008. An overview can be found in the EuroHealthNet document [3]. Also, together with the Ministry of Health, a cross-ministerial coordination group was established to ensure collaboration across political areas on central elements of the action plan. Secondly, a financial pool of €10 million was allocated for developing and evaluating prevention strategies in Danish municipalities [23].
**National Programmes:** The National Board of Health provided EuroHealthNet with the description of two programmes running on in Danish municipalities.

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**The Municipalities plan against Obesity (2005 – 2008)**

Denmark is divided into 98 municipalities. The municipalities apply for financial support from the pool in order to finance different sorts of projects focusing on prevention and treatment of obesity among children and adolescents. In total 31 projects have been set up in the period 2005-2008. All projects have duration of 3 years.

The projects focus on general prevention as well as treatment of obesity. Examples of initiatives related to general prevention are: establishment of diet and exercise policies in schools and daycares, education of professionals in subjects related to nutrition and physical activity, establishment of secure paths for biking, etc. Examples of initiatives related to treatment of obesity are: establishment of a model for recruiting the overweight children and adolescents involving the health care nurses, establishment of coordinated interventions within the municipality involving a central person to coordinate, establishment of a treatment clinic focusing on diet, physical activities and psychological aspects, etc.

**Aim:** The programme is supporting municipality based projects with the following overall purposes:

- To implement structured interventions in a number of municipalities for prevention and treatment of obesity in children and adolescence with special focus on socially exposed children and adolescents
- To secure evaluation of the financially supported projects so that they can be used as future models in Denmark

**Support:** In 2005, the Danish Government established a financial pool of approximately 10 million euro’s. In addition to this sum, 1.3 million euro’s have been allocated for centrally supported initiatives, including a travel team who provide consultancy services for the municipalities in relation to physical activity and overweight, a cross sectional evaluation, conferences and seminars for the professionals working in the municipalities.

**Trigger:** The prevalence of obesity among children and adolescents has increased in Denmark within the last decades. There seems to be a social gradient and gradient between ethnic groups in the prevalence, and there is no convincing evidence as how to prevent or treat obesity.

**Targeted Communities:** The municipalities are responsible for central interventions in relation to children and adolescents in socially exposed families, starting from the first visit of the health care nurse until the child leaves the school. The municipality is thus well qualified to create an organisational framework that ensures a strengthened coordination of the interventions regarding obesity among children and adolescents. The projects in the different municipalities focus on different target groups including ethnical minorities, pregnant women, preschool children etc.

**Evaluation:** The projects will be evaluated separately by the municipalities. A cross sectional evaluation of all projects will be performed centrally. Results from projects finishing in 2008, will be presented in a report in summer 2009. The cross sectional evaluation of all projects will be published in a report in 2012.

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One part of the project is to develop a course for health professionals to increase their qualifications in working with obese adults. Health professionals are educated to advice in weight loss and maintenance of a weight loss, with main focus on motivating the target groups to change lifestyle. The complete course consists of three seminars of three, two and one day, respectively. In between each module the participants do exercises on an e-platform. All together 9 whole days are acquired for the course, which normally is spread out on a four month period. The counselling, in which the participants are trained, is based on a concept called “small steps”. The counselling motivates the target groups to small changes in lifestyle and changes in diet and exercise habits. Examples of small changes are: walk to work, use fat-free milk over whole milk, increases the fiber in the diet.

All 98 municipalities and five regions in Denmark have the option to apply for financial support to projects aiming to test and establish the new weight loss-concept. For the municipalities and regions to receive money, the Danish National Board of Health demands, that the particular project include participation of health professionals in the course of the national weight loss-concept and that the qualifications received on the course are implemented in the project.

There will be two application-rounds for the municipalities and regions to apply for financial support to test and anchor the weight loss-concept. The first application deadline was in July 2008, at which thirty projects were financed. The second application-round is expected to be in May 2009. Furthermore, it will be possible for municipalities and regions to apply the National Board of Health for financial support to offer the course to employees, which is not involved in a project financed by the pool, but work with obese adults through other initiatives.

Another part of the initiative is to create a healthier environment on work places with a high percentage of employees with obesity. This includes qualifying certain employees to become “key persons” at the work place. The key person then has the responsibility to keep informed about local initiatives and share the information with the rest of the employees. Thereby, a better contact is created between the qualified people working with obesity in the municipality and the particular workplace. Furthermore, the work place can apply for money to establish general initiatives to improve the environment for people, who are motivated to lose weight. This includes for instance introducing fresh fruit in the canteen and offering cheap gym-lessons.

The work places can apply the National Board of Health for a supply to establish the project, when the municipality, where upon the work place are located, is establishing the weight loss-concept.

**Aim:** The objectives of the financial pool are:

- To establish initiatives which support adults with obesity in increasing their empowerment for losing weight and maintaining weight loss. These qualifications should be increased by increasing the qualifications among health professionals in their work with obese adults, through a new national weight loss-concept
- To secure evaluation of the financially supported projects and the national weight loss-concept, so that it can be used as a future model for a national weight loss-concept in Denmark

**Support:** In 2007, the Danish Government established a financial pool of approximately 7.7 million euro’s to decrease the inequality in health among socially exposed groups, in particular on the area of weight loss and weight maintenance among obese adults.
**Trigger:** Obesity increases the risk of type 2-diabetes, cardio-vascular disease, hypertension and certain kinds of cancer. 10 – 13 % of the Danish population is obese and the number is increasing.

**Targeted Communities:** The main target groups to receive weight loss and weight maintenance counselling are:

- Ethnical minorities
- Unemployed
- Non-educated employees
- Pregnant women and mothers of newborn babies

**Evaluation:** The projects will be evaluated separately by the municipalities. 0.4 Million euro’s is furthermore earmarked to a cross sectional evaluation of all projects, which will be performed centrally, by an extern evaluator. The cross sectional evaluation of all projects is expected to be published in a report in 2013.

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**Finland**

*(Extra information was provided by the Finish Centre for Health Promotion - EuroHealthNet member)*

**National Strategy:** In 1995, the Finnish National Nutrition Surveillance System was launched with the purpose of collecting, analysing, evaluating and distributing data on the nutritional status, and of assessing the need for measures to promote nutrition and health policies. In addition, through this system, nutritional data are communicated to health care professionals, researchers, teachers, journalists and those working in food production, food trade and mass catering (http://www.ktl.fi/portal/english/) [23].

The Government Resolution on the Health 2015 Public Health Programme (approved in 2002) outlines the targets for Finland’s national health policy for the next fifteen years. The main focus of the strategy is on health promotion, not so much on developing the health service system. Health 2015 is a cooperation programme that provides a broad framework for health promotion in various component areas of society. The prevention of obesity is included in the overall picture of the nation’s health promotion and one of the targets is reducing health disparities between population groups, i.e. small health differences between genders, socio-economic categories and people living in different regions. More information can be found at: http://www.terveys2015.fi/english.html.

Furthermore, the government approved a resolution on Development of Guidelines for Health-enhancing Physical Activity and Nutrition Promotion, coordinated by the Ministry of Social Affairs and Health, the Ministry of Education, the Ministry of Agriculture and Forest, the National Nutrition Council and a Committee on Development of Health-Enhancing Physical Activity. The last two actors are having an advisory role, set by the Ministry of Agriculture and Forest and the Ministry of Social Affairs and Health respectively. The main targets of this resolution are the promotion of population health and the prevention of diseases so that e.g.:
The number of people following nutrition recommendations grows through increasing the intake of vegetables, fruits, and berries and through decreasing the intake of saturated fat, salt, and sugar. Overweight and obesity as well as other health problems related to nutrition and physical activity decrease. Dietary and physical activity habits that promote health become more common especially among population groups with the lowest socio-economic status.

In April 2004, a policy programme for health promotion was adopted by the Government, the Ministry of Social Affairs and Health being the responsible actor. The programme targets have divided in different parts. One part concentrates on the prevention of national diseases by impacting the life-style habits (e.g. by decreasing obesity among children, youth and working adults). Health equity is the main target of the whole programme.

One of the aims of the National Development Plan for Social and Health Care Services (Kaste Programme 2008-2011) is to impact the use of alcohol, smoking and obesity. By diminishing these three risk factors, the programme aims to influence health equity issues.

National Support: In Finland there are two main actors that influence the issues concerning nutrition and physical activity and thus the prevention of obesity. These are the Committee on Development of Health-Enhancing Physical Activity (set by the Ministry of Social Affairs and Health) and the National Nutrition Council (which is an expert under the Ministry of Agriculture and Forestry).

National Programmes: The TEROKA project aims to develop a knowledge base and tools to promote the attainment of the objective of the Health 2015 public health programme for reducing health inequalities. The TEROKA group consists of experts on health differences with a variety of academic backgrounds including epidemiology, health services research, social policy, medical sociology and nutritional science. The practical work is carried out by the project group, which has members from the National Institute for Health and Welfare (THL) and the Finnish Institute of Occupational Health (FIOH). The work is supported by a steering group consisting of the senior management of the Ministry of Social Affairs and Health, THL, FIOH, the Finnish Centre for Health Promotion and the Association of Finnish Local and Regional Authorities.

The main aims of the project are to:

- strengthen the knowledge base and follow-up on health inequalities and disseminate information;
- chart and promote co-operation needed for reducing health inequalities;
- encourage policies on tackling health inequalities as well as practical measures;
- advance the use of health impact assessment as a means for health and social policy attempting to reduce health inequalities.

The actions of TEROKA set out to realize these aims are:

- compile and publish reports on trends in health inequalities;
- maintain and develop internet services, produce educational material and provide presentations and lectures;
- in co-operation with partners, develop and assess national, regional and local operation models aiming to reduce health inequalities;
- explore possibilities to reduce health inequalities by means of health impact assessment;
- gather material for the basis of a strategy and action plan for reducing health inequalities;
- build practical models for regional health inequality follow-ups.
**France**

*(Extra information was provided by the National Institute for Prevention and Health Education - EuroHealthNet member)*

**National Strategy:** In France, there is no specific policy to fight against obesity but a more general policy that promotes a satisfying nutrition (diet and physical activity). A National Nutrition Health Programme (PNNS) was adopted in 2000 for the period 2001-2005, but it thus aimed to improve the general health status of the whole French population rather than combating one specific aspect (obesity).

The National Nutrition Programme was revised in 2006 [34]. This second programme re-evaluated the priority targets and several new actions were added. These actions are targeted more specifically at the underprivileged, more focused on obesity and better adapted to neighbourhoods, aiming at better health care and improved detection. Furthermore, a separate policy document on physical activity was published in 2003 [35].

The actions of the PNNS are organised according to two main strategic orientations: the promotion of a healthy diet and physical activity through information, communication and education, and the development of environments to enable healthy choices.

The communication, education and information actions are constructed on the basis of a framework elaborated on a strict scientific ground organised by political bodies with experts from the public sector only. Many tools are made on this basis by the French INPES (National institute for health promotion and health education). However, the diversity of needs to address different age ranges, sexes, and levels of education requires adapted tools. Those tools can be made by different actors from associations and local political or economic bodies. They are then submitted to the governing bodies before they receive the agreement to receive the logo of the PNNS. This logo is a proof of quality for customers.

**National Support:** The National Institute for Prevention and Health Education (INPES; Institut National de Prévention et d’éducation pour la santé) is a public establishment created by the law of 4 March 2002 relating to the rights of patients and quality of the health care system. Supervised by the Ministry of Health, the INPES has the following missions:

- Implementing public health programmes on behalf of the State and its public establishments (as stipulated in Article L. 1411-6);
- Providing expertise and consultancy in matters of health prevention and promotion;
- Ensuring the development of health education throughout France;
- At the request of the Minister of Health, participating in the management of emergency or exceptional situations having consequences on the general population’s health, and notably in broadcasting health warnings during emergency situations;
- Establishing health education training programmes according to modalities defined by decree.

The actions of the INPES have been taking place in the framework of the PNNS. It is involved in several health promotion programmes, it designs and implements numerous prevention campaigns, and it produces data from research studies and evaluations. More information and an overview of all running programmes can be found on the website of INPES (http://www.inpes.sante.fr).

**National Programmes:** The actions led on a national level give a coherent speech to the whole population, regardless of the level of education or social condition. Specific actions for specific populations are only performed at local level by associations and municipalities. The latter are encouraged to become “PNNS active cities”, so as to take part of a national dynamic. Many actions are financed by local political bodies that validate the interest and coherence of the project.
Germany
(Extra information was provided by the Federal Ministry of Health (BMG) and the Dr. Von Hauner Children’s Hospital, Ludwig-Maximilians-University of Munich)

National Strategy: The Federal Ministry of Health and the Federal Ministry of Food, Agriculture and Consumer Protection have made the promotion of healthy lifestyles the main health and nutrition policy objective, placing strong emphasis on overweight and obesity [23].

Through a variety of preventive measures, national policy promotes prevention-oriented lifestyles, including a balanced diet, adequate exercise and stress management. Among these measures are legislative initiatives, such as the Health Care Reform Act (2000), the Health Care Modernization Act (2004) and the establishment of a network of key players within the framework of the German Forum on Disease Prevention and Health Promotion [2,23].

The National Action Plan for the prevention of obesity in Germany is called ‘IN FORM’ – the German initiative for healthy food choices and more physical activity. The action plan aims to prevent malnutrition, lack of physical activity, overweight and related diseases by motivating people to take care of their own health by means of role models and incentives and to provide concrete offers for individuals and population groups who have little access to health promotion offers. For more information, please visit http://www.in-form.de.

The National Food Consumption Survey (http://www.was-esse-ich.de) aims to collect representative data on the current, normal food consumption pattern, the nutritional status and behaviour of the population and levels of physical activity. The identification of special lifestyle types, their potential connection with body weight and height, as well as socio-economic data, offers a valuable approach for prevention programmes. Nationwide data will be collected on the health status of young people, including diet and physical activity.

These measures will provide an evidence base for the development, implementation and evaluation of health promotion and disease prevention strategies [23].

The Cooperation Consortium “health promotion in socially deprived and handicapped persons” will build up a consortium of 50 organisations. This initiative of the Federal Centre of Health Education which belongs to the Federal Ministry of Health, created a data bank which enables an overview about running and successful projects, especially for people in a complex and complicated setting.

National Support: The German Platform for Diet and Physical Activity, founded in September 2004, is an illustrative example of mobilizing and integrating stakeholders from different groups of society (http://www.ernaehrung-und-bewegung.de). The Platform consists of more than 100 members and actively promotes 32 innovative programmes. An expert committee comprising scientists from various areas supports the Platform scientifically. In November 2005, the Platform opened its own office for the coordination of activities. The goal of the Platform is to bring together as many players in society as possible to ensure a balance between healthy nutrition and healthy exercise and thus promote a healthy lifestyle from the outset [23].

The Federal Centre for Health Education (BZgA) was established in 1967 with the following tasks:

- the elaboration of principles and guidelines for the contents and methods of practical health education;
- the training and further education of persons active in health education;
- the coordination and strengthening of health education in the Federal Republic of Germany;
- cooperation with agencies abroad
The BZgA implements many projects and measures for prevention and health promotion, and sees these two topics as being tasks for society as a whole. It cooperates with numerous partners in order to be effective both in specific target groups and across the entire population. For more information, please visit [http://www.bzga.de](http://www.bzga.de).

**National Programmes:** A description of the following programme - running at national level - was provided by the Ludwig-Maximilians-University of Munich.

**Tigerkids**
[http://www.tigerkids.de](http://www.tigerkids.de)

Prevalence and severity of childhood obesity have increased at alarming rates, with serious consequences for the health and well-being of affected individuals, as well as costs arising for health care systems and societies. “TigerKids”, a behavioural intervention programme for Kindergarten settings, was developed by the Child Health Foundation, Munich, the Ludwig-Maximilians-University of Munich, and the Bavarian Health and Food Safety Authority in cooperation with other competent partners to prevent obesity. The evaluation during the pilot phase showed significant intervention effects, especially in eating habits of the children, so that AOK health insurance promotes the actual roll-out in ~ 2.600 kindergartens in Germany. In this manner TigerKids can reach nearly 125.000 children and their families. TigerKids elements and materials were designed for kindergarten teachers, children as well as parents to promote healthy lifestyle in the kindergarten setting and at home. At the start of the intervention, all teachers of participating day care centres attended a two day training workshop in which they were introduced into the concept and practical application of the TigerKids programme. Parents were informed with the help of newsletters and Tipp-Cards providing messages on health related behaviour. Furthermore, information evenings at each Kindergarten setting and an internet platform are offered for interested parents.

A pilot phase was conducted from October 2003 till July 2006. The nationwide roll-out of the project in all 16 states of Germany started September 2007 and will end presumably 2009. After this time the TigerKids programme will go on in all participating kindergartens.

**Aim:** The primary goals of this project are to modify children’s’ regular physical activity as well as food and drink choices. A secondary goal is to limit consumption of television and other electronic media. Modules for use in Kindergarten settings were developed in collaboration with experts in pre-school education, sport and nutrition sciences, and paediatrics. Key targets are that children should reach:

- At least 30 minutes/day of vigorous physical activity in the Kindergarten
- Consumption of at least two portions/day both of fruits and of vegetables
- Intake of not more than one glass/day of sugared drinks and juices
- <1h/day television or electronic media consumption.

**Support:** The development, pilot testing and evaluation of the intervention was financially supported by the Bavarian State Ministry of Environment, Public Health and Consumer Protection. Additional support was provided by AOK Health insurance Bavaria, Lions Club Munich, Südzucker AG Mannheim and Kraft Foods Munich. The actual nationwide roll-out is financially supported by AOK Health insurance Germany.
The following partners are involved in the development of the programme: the Child Health Foundation, AOK Health Insurance, Div. Metabolic Diseases and Nutritional Medicine of the Dr. von Hauner Children’s Hospital, Bavarian Health and Food Safety Authority, Institute for Social Paediatrics and Adolescent Medicine, Ludwig-Maximilians University, Research Centre for Physical Education and Sports of Children and Adolescents, State Institute of Early Childhood Research and the Bavarian State Ministry of Environment, Public Health and Consumer Protection.

**Trigger:** The observed increase of obesity prevalence already at primary school entry with 5-6 years over the last two decades (Kalies H et al.; 2004) suggests that the basis of obesity development is already established in early childhood. Therefore, the development and implementation of effective prevention strategies at an early age is of utmost importance, but at present only very limited data on the effectiveness of childhood obesity prevention programmes from randomized controlled trials are available, and no generalisable conclusions can be drawn (Collins CE et al.; 2006, Stice E et al.; 2006, Summerbell CD et al.; 2005 and Pigeot I et al.; 2004). Bluford et al (2007) identified only five prevention programmes addressing obesity risk in preschool children that were evaluated. While most of these studies enrolled only relatively small numbers of children (ranging from 40 to 745 subjects) often followed for short periods of time (from between 14 weeks to 1 year), two of the five programs reduced weight or fat status. The authors concluded that there is a need to evaluate more programs aiming at prevention of early childhood obesity with inclusion of objective behavioral measures. We developed and evaluated a low-cost behavioural intervention programme for use in Kindergarten day care settings in a sizeable, cluster-randomized study with a duration over two Kindergarten years (2003 - 2006). The nationwide roll-out (2007 – 2009) is an advancement of the pilot phase.

**Targeted Communities:** Tigerkids reaches nearly 125,000 children in about 2,600 kindergartens in Germany.

**Evaluation:** The TigerKids intervention programme was evaluated during the pilot study. In July 2004, 64 kindergartens in four Bavarian regions were randomly assigned as intervention or controls in a 2:1 ratio. Samples of 1318 and 1340 children were investigated in the school entrance health examination 6 and 18 months after TigerKids started in the kindergartens. The main outcome measures were the prevalence of high fruit and vegetable consumption, low consumption of high caloric drinks assessed in food questionnaires filled by parents, of overweight and obesity, and secondary, further dietary habits and results of motoric testing. A significant higher consumption of fruits and vegetables reported in the intervention group was found both after 6 and 18 months. Subgroup analyses by gender, overweight and parental education, performed in order to assess consistency of these effects, showed similar results. A significant lower consumption of high caloric drinks and snacks while watching TV was only observed in the TigerKids group after 6 months. The TigerKids intervention resulted in sustainable positive effects on fruit and vegetable consumption in young children 18 months after start of the programme. A large scale study in ~ 500 Kindergartens in Bavaria to assess whether these and potentially unmeasured effects will also result in a reduction of childhood overweight is therefore warranted. Results are expected April 2009.

At last, materials from existing intervention programmes, such as the German TigerKids programme, are identified as one of two European model programmes for obesity prevention by the EU White Paper on A Strategy for Europe on Nutrition, Overweight and Obesity related health issues (2007).

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*(Extra information was provided by the Harokopio University in Athens)*


In the same year, the Ministry of Health and Social Welfare established the National Nutrition Policy Committee. The Committee set priorities and the following initial goals:

- to reduce the consumption of meat;
- to increase the consumption of fish;
- to reduce childhood obesity;
- to increase the consumption of pulses and vegetables;
- to improve the quality and safety of food provided through mass catering services and increase consumer awareness of food quality and safety.

In March 2006, the Committee submitted its proposals for the development of a European Green Paper on the promotion of healthy diet and physical activity and the prevention of overweight, obesity and other chronic diseases.

In the context of addressing the issue of childhood obesity, the Committee has also developed an action plan for the implementation of national nutrition guidelines in schools. Furthermore, dietary recommendations have been formulated for nursery schools and summer camps. The establishment of national obesity clinics and research centres is also under way with the aim of providing free medical and dietetic care to patients who require specialist help and support.

Regarding Primary Education, the National Foundation for Youth and the Ministry of Education has just published two manuals for school based health promotion activities in this field: (a) *Nutrition and Dietary Habits* and (b) *Physical Activity and Health Indices*. Both of these manuals were launched this Academic year aiming to provide a bases and guidance for activities in these thematic areas and promote the adoption of a healthier way of leaving among children and their families.

**National Programmes:** The following two examples of scientific studies that run at national level in Greece were provided by the Harokopio University in Athens.

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### GENESIS Study

The GENESIS Study is an abbreviation for: ‘Growth, Exercise and Nutrition Epidemiological Study In preSchoolers’. It is a large-scale epidemiological study conducted in Greece, attempting to assess growth, development and nutritional status of preschool children. Moreover, the study aimed to identify the most vulnerable subgroups in the population and the potential reasons leading to childhood obesity and poor dietary habits.

Between April 2003 and July 2004, 2,374 children, aged 1 to 5 years old were recruited in the study (response rate was 75%). These children were enrolled from a representative sample of randomly selected public and private nurseries as well as day-care centres within municipalities in five counties of Greece. All nurseries invited to participate responded positively.

Among the total number of nursery schools studied (n=115), 63 were in Attica, 10 were in Thessalonica, 12 were in Halkidiki, 22 were in AitoloaKarnania and 8 were in Helia. The sampling of the nurseries was random, multistage and...
stratified by the total population of children, according to data provided by the National Statistical Service of Greece (Census 1999). The selected counties are widely scattered over the Greek dominion while their overall local population comprises about 70% of the total population (Census 1999).

After adjusting for parental age and educational level of the population agreed to participate in the study, no significant differences between the overall population characteristics and the study sample within counties, according to data provided by the National Statistical Service of Greece (Census of 1999) were observed.

**Aim:** The Project aimed to increase knowledge and understanding of scientists and public health policy makers on the parameters leading to childhood obesity, and to provide guidance and guidelines that could be used in developing and applying public health approaches for the overall population.

**Support:** Approval to conduct the study was granted by the Ethical Committee of Harokopio University of Athens and by all municipalities invited to participate in the study. The GENESIS study was supported with a Research Grant from Friesland-Foods Hellas.

**Targeted Communities:** The study focused on preschool children (one to five years old) in Greece.

**Evaluation:** Several reports have been published and others are in process. These papers confirm that preschoolers in Greece are characterized by poor dietary habits, sedentary life (TV viewing hours) and increased prevalence of obesity. Moreover, these findings are more common among children from families with low socio-economic status.

Reports that have been published up till now are:


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The “Prediabetes, Obesity and Growth Epidemiological Study in Schoolchildren” (PROGRESS study) is an ongoing epidemiological study initiated in September 2007 following a pilot phase in May 2007. It aims to record the prevalence of several clinical conditions related to obesity as well as to identify those lifestyle and behavioural patterns that interact for their manifestation. The under study population comprised primary schoolchildren (10-12 years old).

The sampling of schools was random, multistage and stratified by parental educational level and the total population of students attending schools in six counties from the central, northern, southern and western parts of Greece, namely Attica, Aitoloakarnania, Iraklio, Lasithi and Thessalonica. More specifically, all municipalities in these counties were divided into 3 groups based on the average educational level of their adult population (25 to 65 years old) (Census 2001). This procedure yielded two parental education cut-off points that were used to categorize municipalities into 3 categories with different socio-economic level (SEL) i.e. Higher, Medium and Lower SEL.

Consequently, based on data provided by National Statistical Service of Greece, a certain number of municipalities that was proportional to the size of their childhood population (10-13 years old) was randomly selected from each one of these three SEL groups. Finally, an appropriate number of schools was randomly selected from each one of these municipalities in relation to the population of schoolchildren registered in the 5th and 6th class in each municipality (data obtained from the Greek Ministry of National Education).

An extended letter explaining the aims of the study and a consent form was provided to each parent or guardian having a child in these schools. Those parents that assented participation of their child in the study had to sign the consent form and return it to the research team members. Until June 2008 signed parental consent forms were collected for 754 children and complete data became available for 729 children. The study will be completed by June 2009, envisioning to assess a cohort of minimum 2500 children.

**Aim:** The primary aim of the current study was to record the prevalence of several clinical conditions (i.e. insulin resistance, hyperlipidemias, hypertension, obesity, metabolic syndrome, iron and other micronutrient deficiencies etc) as well as to identify those lifestyle and behavioural patterns that interact for their manifestation. Increasing our knowledge and understanding on the effect and interaction of such patterns will pave the way for the implementation of appropriate public health initiatives to tackle these adverse health issues early in life.

**Support:** Approval to conduct the study was granted by the Greek Ministry of National Education and the Ethical Committee of Harokopio University of Athens.

**Targeted Communities:** The under study population comprised schoolchildren aged 10-12 years attending primary schools located in municipalities within six counties in Greece.

**Evaluation:** Several presentations (both oral and poster) derived from the preliminary data of the PROGRESS study have been presented in several congresses so far (1-4), while an original research paper is under consideration for publication in a special issue of the journal “Public Health Nutrition” (5). These reports indicated a considerably high prevalence of overweight and obesity, hyperlipidemias, insulin resistance, hypertension, metabolic syndrome and iron deficiency in children, specific dietary and physical activity patterns, perinatal indices, socio-economic, cultural and demographic characteristics were some of the parameters that were found to exert a significant effect.
References:


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Ireland

*(Extra information was provided by the Health Promotion Unit of the Department of Health and Children – EuroHealthNet member)*

**National Strategy:** The National health promotion strategy 2000-2005 was set up by the Ministry of Health and Children, one of its issues to tackle being lifestyle behaviour / food and nutrition, and exercise. It also recognizes the existence of social variations in health and lifestyle behaviours between the lower and higher socio-economic groups and the challenge for health promotion to narrow this gap [37].

In March 2004 the Minister for Health and Children established the National Taskforce on Obesity as a direct response to the emerging problem of overweight and obesity in Ireland, particularly in children. The aim was to develop a strategy to halt the rise in and reverse the prevalence of obesity. The Taskforce report set out a series of recommendations directed at a number of sectors – High level Government, Education; Social & community; Health; Food, commodities, production & supply; and Physical environment [38].

Ninety-three recommendations were made, related to actions across six broad boarders. One of them – ‘Social and Community’ – includes a recommendation (number 8) concerning disadvantaged communities. It states that:

‘Peer-led community development programmes should be fostered and developed to encourage healthy eating and active living. These programmes should be prioritised for lower socio-economic groups, ethnic minority groups, early school leavers, people with learning and physical disabilities and they should be based on the principle of developing self-esteem and empowerment such as is evident for example in the community mothers programme.’

Also the ‘Physical Environment’ sector refers to lower socio-economic groups in two of its recommendations (number 15 and 20):
The private leisure industry should be encouraged to make its facilities more accessible to lower socio-economic and minority groups through partnership with local communities, local authorities and health boards.

Community development programmes which encourage healthy eating and active living should be developed in partnership with local authorities and businesses. These programmes should be prioritised for lower socio-economic groups, ethnic minority groups, early school leavers, and people with learning and physical disabilities.

The Department of Health & Children (DoHC) has recently established an intersectoral group to monitor and evaluate implementation of the strategy, and this group is due to report in April 2009.

In accordance with one of the key recommendations of the Taskforce, the DoHC is currently finalising a National Nutrition Policy. The aim of the NNP is to achieve better nutritional health for the total population, but it will focus particularly on children and young people, to help halt the increase in obesity and to reduce food poverty.

National Support: The Irish Heart Foundation, Ireland’s national charity for heart health, runs a range of programmes focused on promoting heart health and addressing obesity in schools, workplaces and communities. However these are general programmes and not specifically aiming to target disadvantaged communities. More information can be found at: http://www.irishheart.ie.

The Nutrition and Health Foundation (NHF) is a multi-stakeholder initiative established by the food and drink industry in Ireland. It brings together industry, government, scientists, health professionals and other relevant stakeholders. The NHS is developing programmes for the workplace and General Practise promoting healthy eating and physical activity [2]. For more information please visit http://www.nutritionandhealth.ie.

Healthy food for all is an initiative seeking to address diet-related ill-health and to ensure access to healthy and affordable food to the whole Irish population.

The publication and extensive dissemination of the Food Poverty and Policy Report highlighted the issue of food poverty as one of major concern for food and nutrition policy in Ireland. The findings of the report were debated with the Oireachtas, the food sector, HSE community dieticians, anti-poverty organisations, government departments (health, agriculture and social welfare), local authorities and other interests.

In line with the recommendations of the report a feasibility study was undertaken on the establishment of a network of community food initiatives. The results of this study were debated at a roundtable of key interests in April 2005. There was broad support at the roundtable for the establishment of the Healthy Food for All initiative. A number of follow-up discussions with other interests were held in order to refine the proposal for the establishment of an initiative to address food poverty.

Living in poverty and social disadvantage can affect diet in a number of ways:

- **Affordability** is a huge issue, affecting the choice and amount of food that can be bought.
- **Access** to shops can be problematic, as retail options, transport and storage/cooking facilities are often limited.
- **Availability** of healthy food in local shops may be an issue; they may not stock healthy options, such as fruit and vegetables, for a number of reasons including shorter shelf life, lower profit, a perceived lack of interest or a shortage of storage options.
Awareness of what constitutes a healthy diet affects food consumption. There is a lot of misinformation surrounding nutrition and many people lack the knowledge and skills to prepare and cook a meal from scratch.

The Healthy Food for All initiative has three key objectives:

1. **Community**: To support local initiatives which promote availability and access to healthy and affordable food for low-income groups, with a focus on community food initiatives and direct food provision, including school meals;
2. **Network**: To develop an all-island learning network to identify best practice on promoting healthy food for low-income groups and to develop links with similar organisations in the UK and Europe
3. **Policy**: To promote awareness of food poverty across all aspects of public policy, with a focus on food affordability, access and availability.

**Aim**: The aim of Health Food for All is to end food poverty in Ireland.

**Support**: Funding was received for the establishment of the initiative. Crosscare agreed to house the initiative in its' developmental phase. A project co-ordinator was employed in September 2006. The co-ordinator is supported by a management committee and an advisory committee. In 2008 Healthy Food for All was awarded funding by safefood to set up a Demonstration Programme of Community Food Initiatives.

**Trigger**: In 2006, 290,000 people or 7% of the population were living in consistent poverty in Ireland. Consistent poverty means that they are living on a low income and are deprived of one or more basic necessities, including food related items.

- 11% went without a substantial meal on at least 1 day in the past 2 weeks
- 11% were unable to afford a roast once a week
- 9% were unable to afford a meal with meat, chicken or fish every 2nd day
- 30% were unable to afford to have family or friends around for a meal or drink once a month

**Targeted Communities**: The initiative was set up to support those who don’t have access to healthy food due to poverty and/or social disadvantage.

**National Programmes**: In 2005, the Irish Government launched a pilot scheme in 150 primary schools across Ireland called Food Dudes. Two years later the Irish Government decided, due to the success of the programme, to introduce it to every primary school in the country. This national roll-out is proving both successful and very popular and is being funded by the Department of Agriculture, Fisheries and Food and managed by Board Bia. More information can be found on the website http://www.fooddudes.ie.

An extensive overview of other running programmes in Ireland can be found in the EuroHealthNet report [2].
Netherlands

National Strategy: In its policy document, Living longer in good health 2004–2007, the Dutch Government sets itself the task of halting the increase in the number of overweight adults and, in the case of children, of reversing the trend (WHO report).

Concerning health inequalities the policy document refers to a report, published by the National Institute for Public Health and the Environment (RIVM) in 2006 called Public Health Forecast 2006 (Volksgezondheid Toekomst Verkenning (VTV) 2006). This report describes major disparities in health due to socio-economic differences among population groups.

The National Institute for Public Health and the Environment has also set up a Monitor for health inequalities that specifically occur among lower socio-economic communities. Two of the health determinants that are being measured are overweight and physical activity.

To tackle the problem of obesity from a wide range of perspectives, the Ministry of Health, Welfare and Sport drew up the Covenant on Overweight and Obesity towards the end of 2004. The covenant (signed in January 2005) is an important pillar of the Ministry’s policy to address overweight. The quantitative goals include halting the increase in the number of overweight adults and reducing the number of overweight children by 2010. The Covenant, which is not enforceable by law, and was chosen as the Netherlands’ platform for promoting the use of measures other than the more traditional policy-making and implementation instruments for counteracting overweight. In this respect, it emphasizes communication, self-regulation, self-implementation, self-enforcement, implementation based on “real life” scenarios, networks of mutually dependent actors, knowledge and information for effective action.

Through their own activities and the roles they play in society, all parties to the Covenant look for ways to contribute to achieving the Government’s targets on overweight. Their individual plans have resulted in an action plan entitled: Striking the right energy balance.

The Action Plan recognizes that - as action targeting the entire population will seldom be effective - two target groups require special attention. Besides children and young people, these are communities with a lower socio-economic status as well. As stated in the report:

“Various studies have shown that excessive weight gain is especially prevalent among people of low socio-economic status (SES). A combination of factors makes this group particularly susceptible. We shall try to develop activities specifically targeting them. This will necessitate cooperation at local level (with municipalities and other local partners).”

More information about this Covenant on Overweight and Obesity can be found in the WHO and EuroHealthNet report, or on the website of the Covenant: http://www.convenantovergewicht.nl/english.

National Support: The Netherlands Nutrition Centre (Stichting Voedingscentrum Nederland; http://www.voedingscentrum.nl) is an independent organisation, funded by the Netherlands Ministries of Health, Welfare and Sport (VWS) and Agriculture, Nature and Food Quality (LNV). The Centre’s key tasks are:

1. to provide scientifically reliable, honest information to consumers about the quality aspects of food and food production and about safe and healthy nutrition;
2. to use active communication campaigns and specific projects to achieve changes in behaviour that lead to healthier and safer eating patterns by consumers and/or concrete health gains;

3. to interact with scientific, commercial, political and public communities in order to further the missions’ goal

Apart from conducting many public (mass media) campaigns designed to stimulate healthy and safe eating, the Nutrition Centre published ‘The Netherlands in balance: preventing obesity master plan 2005 – 2010’ in 2005. Central to this plan is the promotion of a healthy energy balance (healthy eating and exercise) among Dutch consumers [41].

More can be read about the campaigns from the Nutrition Centre in the WHO report [2].

National Programmes: Many national campaigns are described in the WHO and EuroHealthNet report [2,23].

A programme that is not described in this report is the SchoolGruiten project; the largest free fruit and vegetables scheme for Dutch primary school children. It started off with a pilot phase in February 2003, initially aiming to target schools in areas of deprivation. However, during autumn 2006 the project was transformed into a general programme providing the possibility for all schools in the Netherlands to participate. As youth in general are not eating enough fruits and vegetables, it was decided to change the design and thus not to discriminate anymore between different socio-economic groups.

However, every region in Holland has its own arrangements concerning the delivery of the programme. Amsterdam for instance, chose to proceed with the original idea and is still providing the project to schools in deprived areas only. Thus, on a national level the programme is broadly implemented, but in some cities it specifically aims to target the lower socio-economic communities.

Below the programme is generally described. In chapter four, the project running in Amsterdam with its different target groups is included. More information can be found on http://www.schoolgruiten.nl.

SchoolGruiten is a Dutch acronym for ‘school fruits and vegetables’. The word ‘Gruiten’ comes from the two Dutch words ‘groenten’ and ‘fruit’ (vegetables and fruits, respectively). It aims to change nutrition behaviour of 4 to 12 year old children. During the Project:

- Children are acquainted with fruits and vegetables in a fun and playful way
- Children will be encouraged to develop their taste
- Children will be showed that healthy food is important – now, and also when they are adults.

Both teachers and schoolchildren will eat vegetables and fruits during two fixed days a week together in the classroom. This behavioural component – eating together – stimulates children to try new things and to distinguish between several varieties. By having two fixed days during the week, their fruit and vegetable consumption will become an integrated part of their daily life. It is important that children not only ‘think’ about the problem, but that they actually ‘act’ as well, and thus eat the provided products.

In addition, materials such as videos and posters were developed to support the initiative and to provide materials to the schools so that teach the children about healthy nutrition. However, the consuming behaviour of the kid primarily stays the responsibility of the parent.
One of the conditions for the school to join with this Project is that the whole school (or at least most of the children) is participating, because the strength of SchoolGruiten is eating the fruits and vegetables altogether.

The SchoolGruiten Project started with a pilot phase in February 2003, in which the intervention was tested in a controlled design to study further improvement and implementation needed in order to grow into a successful nationwide campaign. The focus of the Project was primarily to provide free fruits and vegetables to schools in deprived areas.

The pilot took place in seven different cities in the Netherlands; Deventer, Leiden, the Hague, Almelo, Zwolle, Dordrecht and Breda. It thus focused on communities with a low socio-economic status and was providing free fruits and vegetables for a full year. The pilot was financed by the Ministry of Health, Welfare and the Environment.

Based on the pilot, three ‘Gruitmodels’ were developed for schools to join the initiative, distinguished from each other by the way the portions of fruits and vegetables are reaching the schools (however, so far no school has ever chooses model number two).

**Model 1:** delivery by a subcontractor (delivery service)

**Model 2:** the school goes to a subcontractor to get the products their self

**Model 3:** Parents or child carers give fruits and vegetables to their children to bring to school

When a school decides to cooperate with a subcontractor, one of the conditions is that a participation of at least 100 children is required. Furthermore, at least three quarters of the participating classes should exist of children who are participants of the Project. When a school exists of less than 100 pupils, participation with a high percentage of children is required.

Schools can either select a subcontractor from a list that is provided by the initiative, or it can get in contact with a new delivery service in the neighbourhood of the school. Participation of the program is extended every year automatically.

The basic selection of the fruits and vegetables consists of apples, pears, mandarins, mini cucumbers, small tomatoes, bananas, kiwis and carrots. These fruits and vegetables have been proven to be liked the most by children. When a subcontractor provides kiwis, it needs to provide spoons as well. These spoons need to be kept and recycled by the schools the next time the delivery contains kiwis.

The concept of the Project is that during 40 school weeks, portions of fruits and vegetables are delivered twice a week. Model one is calculating € 0.20 per portion (including taxes), and will thus comes down to a total amount of € 16 euro’s a child per year. Model two will cost the parent a bit less, € 0.1625 per portion, and thus a total amount of € 13 euro’s per child per year is required.

When a school decides to leave it up to the parents to give their kids fruits and vegetables to bring to school twice a week, it is very important that the school constantly reminds and stimulates the parents to really do so, and to vary in the products they give to their child(ren). As an encouragement and stimulus, Gruitboxes are provided when a school decides to choose Model three. These boxes are having such a shape, that besides a sandwich, a apple fits in as well.

Schools that are structurally and actively participating with the SchoolGruiten Project can request for a SchoolGruiten hallmark. This will distinguish them from other schools that are not participating with the Project.

At the moment 450 schools are registered and are thus participating in the SchoolGruiten Project. However, it is likely that more schools have established a similar scheme, but since they prefer to follow their own rules or did not wanted to bind their selves to SchoolGruiten as there is no registration duty.
**Aim:** The SchoolGruiten project, the largest-scale free fruits and vegetables scheme for Dutch primary-school children, aims to improve accessibility of fruits and vegetables at school by providing a serving of fruit or vegetable to all children twice weekly.

**Support:** SchoolGruiten is a joint initiative of the Dutch Ministry of Health, Welfare and Sport (VWS), Horticulture manufactures, Holland Produce Promotion and the Dutch Nutrition Centre. It collaborates with the Dutch Ministry of Agriculture, Nature and Food Quality (LNV) and the Dutch Ministry of Education, Culture and Science (OCW).

The Project can be financed in three different ways

1. By the school itself
2. By the parents
3. By a third party (like a health insurance, municipalities etc.)

If the parents finance the costs of their child(ren), they will receive a authorization form for a one time collection a year. The school will provide and receive those forms. When the school or a third party will finance the project, the money can directly be transferred to the subcontractor.

In order to facilitate the finances and to reduce the administrative work for a subcontractor, the GIS logistic system was developed. Schools can import the data of participating children and the financial details of the parents into this system, which the subcontractor can access and then send to the bank.

Every region in Holland has its own arrangements concerning the financial compensation of the products delivered. Some schools ask for a full coverage from the parents, other schools (for instance in the South of the province Limburg) offer 10 weeks of free fruits and vegetables and after the parents are ask to pay. However, the municipality of Amsterdam decided to fully cover all expenses needed for the Project, and schools are thus providing free fruits and vegetables.

**Trigger:** Most children in the Netherlands do not comply with recommendations for fruit and vegetable intake (150 grams of vegetables and 2 pieces of fruit a day. For children of 12 years and older, the recommended amount of vegetables is 200 grams a day). Since 1987, the intake in grams has dropped by 16% (fruits) and 17% (vegetables) (Tak et al. 2008).

**Targeted Communities:** The programme was set up for all primary schools in the Netherlands who are interested in participating.

**Evaluation:** SchoolGruiten has already been proven to be effective. From an extensive study at around 300 primary schools with in total around 75,000 children and 7,000 teachers involved in seven different cities, turns out that indeed the children at the Gruitschools are eating more vegetables: From 1.1 portions a day to 1.6 portions a day. Teachers criticize the project as very positive (grade: 8.5/10) and children enjoy eating together in the classroom. By providing them with the possibility of eating together, they dare to try new fruits and vegetables faster as before.
Norway
(Extra information was provided by the faculty of Medicine of the University of Oslo)

National Strategy: The strategy document ‘A healthy diet for good health’ [42], commissioned by the Norwegian Directorate for Health and Social Affairs, was drawn up by the Norwegian National Council for Nutrition and handed over to the Ministry of Health and Care Services in June 2005. Eleven ministries were involved in the development of the document, including the Ministries of Health, Agriculture, Fisheries, Children and Equality, Finance, Industry and Trade, and Education and Research [23].

One of the primary objectives of the work in the areas of nutrition is to reduce social disparities in health. To this end, the National Council for Nutrition has designated the following five high-priority areas.

1. Healthy choices (lowering the prices of fruit and vegetables, raising the prices of energy dense, nutrient-poor foods, and preventing the marketing of unhealthy foods to children and adolescents).
2. Educational institutions (providing free fruit and vegetables in day-care centres and schools, and ensuring basic health literacy, basic cooking skills and good teaching skills).
3. Health and social services (intensifying nutrition-related work in prenatal health services, children’s health clinics, school health services, nursing and care services and primary and specialist health services, and enhancing nutritional knowledge among health care personnel).
4. Research and monitoring (focusing on health-promotion and disease prevention measures that address public health challenges; conducting regular studies of eating habits and diet-related health and disease indicators in the population; and monitoring height, weight, blood pressure and various blood parameters).
5. Communication (placing more emphasis on communication to enhance the public’s knowledge about food, diet and health).

The Norwegian Action Plan on Nutrition (2007-2011) ‘Recipe for a Healthier Diet’ was developed by twelve ministries and serves as a tool for decisionmakers, professionals, experts and others in the public and private sectors and NGOs that play a role in the population’s diet [43]. One of the two main goals of this Action Plan is to reduce social inequalities in diet.

The Action plan for physical activity 2005–2009: ‘Working together for physical activity’ [44] was adopted by the Parliament in 2005. The result of the joint effort of eight ministries, it contains 108 measures spread across diverse areas of the community, such as kindergartens, schools, workplaces, transport and urban planning, and leisure activities. A communication strategy for 2005–2009 was also developed to increase knowledge about physical activity and health and to motivate people to adopt an active lifestyle. A coordinating group, including representatives from all eight ministries, meets regularly to implement the different initiatives of the plan. The Directorate for Health and Social Affairs will coordinate the follow-up of the plan [23]. The Action Plan acknowledges the fact that the number of physically active persons increases according to the level of socio-economic status, and it foresees the challenge is has, to promote physical activity within these groups.

National Programmes: Information about running campaigns can be found in the WHO report and on the website of the government of Norway: http://www.regjeringen.no. At the moment none of these programmes are focusing on the communities from deprived areas in Norway specifically.
Portugal
(Extra information was provided by the Ministerio da saude; da Plataforma Contra a Obesidade)

National Strategy: The National programme against obesity [43] is integrated in the National health plan 2004 – 2010 [46], together with other programmes such as the National Programme on Integrated intervention of Health Determinants Related to Lifestyles, the National Programme on Diabetes Control, the National Programme on Prevention and Control of Cardiovascular Diseases and the National Programme against Rheumatic Diseases.

The National programme against obesity aims to contribute to weight loss in the obese and those affected by Type 2 diabetes and cardiovascular diseases, and to combat habits leading to overweight. In general terms, it aims to contribute to the development of a culture that promotes healthy weight in the Portuguese population through intersectoral cooperation. The objective of the programme is, in this way, to reverse the increase in the prevalence of pre-obesity and obesity in Portugal [2, 23]. More information about this national programme can be found in the documents published by EuroHealthNet and the WHO.

National Support: The National Platform against Obesity (Plataforma Contra a Obesidade - http://www.plataformacontraobesidade.dgs.pt) has a special focus on the understanding of the socio-economic determinants of obesity. For example, the Platform has a Local Governments based project, which is trying to identify children with increased needs in this area.

National Programmes: One of the running programmes of the National Platform against Obesity is the POZ project.

The main purpose of the “Projecto Obesidade Zero” (Zero Obesity Project) is to develop a healthy cooking programme and a nutritional guidance programme targeted at low income families with overweight children. This action will be available and articulated with healthcare centres and town halls. Protocols will be established, according to which the healthcare centres and the town hall health offices will direct people to this service.

This project will last one year with the following development stages:

- Planning, defining the calendar and establishing agreements with the different partners.
- Constitution of regional teams for the cooking workshops and of guidance teams for individual and group counselling.
- Field work – organising cooking workshops, therapeutic groups, individual and group counselling.
- Assessment, with regular monitoring of the work done.

The expected results are: 1) Development of competences, within the families, in healthier food selection and preparation, especially in those families with obese children, and 2) Making nutritional guidance available to families with obese children, in a comprehensive and motivational process based on the work of the healthcare centres.

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Romania

National Strategy: The National Action Programme for Health and the Environment was adopted in 1998 and included actions on environmental components (e.g. water, radiation protection, social responsibility etc.), but also nutrition and food safety [2, 23].

A National Strategy on Public Health was adopted in 2004 and includes health promotion and preventive medical services.

National Programmes: Since 1998, twenty-seven national health programmes have been implemented at national level. One of them is the National Programme for Health Education and Health Promotion. All programmes include a health promotion and health education component, and are financed by the Ministry of Health. They consist of annual campaigns and health promotion actions. In 2008 there was a distinct programme called: ‘the National Programme on Health Promotion’, which included the National Strategy on Health Promotion.

Further national action plans for nutrition are found in the National Public Health Programme ‘Evaluation of nutritional status of population’ [2].

Slovakia

(Extra information was provided by the Public Health Authority of the Slovak Republic – EuroHealthNet member)

National Strategy: Slovakia has developed two main strategic documents/declarations, which are oriented on nutrition, physical activity and obesity prevention.

The Health State Policy of the Slovak Republic was approved by the Slovakian government in 2000. One of the priorities of the Health State Policy is the National Program of Health Promotion. This program was updated by the government in 2005. Based on this program, the National Public Health Authority developed the National Program on Prevention of Obesity. In scope of this National program on prevention of obesity will be carried out the following activities:

1. Developing the cooperation between the Consulting Centre of Health Protection and Promotion at Regional Public health Offices and general practitioners for adults, general practitioners for children and youth.
2. Creating partnership and improving a communication and cooperation between health care providers and public health authorities (especially using systematic and legislation tools).
3. Addressing media partners with the request of providing a room for propagation of Consultation Health Centers at Regional Public Health Offices (their work activities and importance of diseases prevention which are linked also to obesity)

More information about these documents, and other thematic documents that were derived as a result can be found in the WHO and EuroHealthNet report [2, 23].
National Programmes: The National Public Health Authority developed the National Program on Prevention of Obesity in January 2008. The overall aim of the program is to establish an energy balance by promoting healthy nutrition and physical activity with a consequent reduction in the prevalence of obesity in all population groups. A multidimensional approach has been suggested involving individuals, communities and several policy sectors. It is proposed to take action in community setting, such a school, workplaces, catering services, public health and health care services, and through policy education.

Programs, which are currently running in Slovakia and are not mentioned in EuroHealthNet and WHO documents are:

- "Challenge your hearth towards physical activity" - it is the national campaign focused on adult population to raise awareness of the importance of physical activity
- "Healthy children in healthy families" - targeted for children of age group 7 - 17 years
- "The program of healthy nutrition for Slovak population" - focused on improving of nutrition habits of the population
- "Monitoring of nutritional habits and preferences of selected children population and evaluation of risks connected with particular food consumption"

More information with regard to these programmes can be given by:

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Slovenia
(Extra information was provided by the National Institute of Public Health of the Republic of Slovenia – EuroHealthNet member)

National Strategy: The National Assembly of the Republic of Slovenia adopted in May 2005 the Food and Nutrition Action Plan for Slovenia (2005-2010) (FNAP). The main goals of the plan are: to increase the consumption of good quality, locally- and ecologically-produced healthy foodstuff; to stimulate the development of local economies and rural development; to create new market opportunities for local farmers; and to contribute to environmental protection [2, 23]. One of the target groups of the action plan that are being particularly at risk are the lower socio-economic classes. It therefore aims to 'Strengthen multi-disciplinary programmes and the execution network for health promotion in local communities, especially for socio-economic population groups at risk'[47].

Another strategy that was adopted is the National Health Enhancing Physical Activity Programme (2007-2013) (HEPA) [48]. Based on results from the national CINDI study carried out in 2001, the goal of HEPA is to 'encourage all forms of regular physical activity and exercise aiming to enhance health and to be maintained throughout the entire lifetime.' Regarding disadvantaged communities, one of the aims of the programme is 'strengthening the values, awareness and knowledge of the entire population with regard to physical activities that enhance health, irrespective of their age, gender, educational level, socio-economic status, the functioning of the locomotory system and other factors'.

Both programs have common goals in counteracting obesity. They have been created in an integral and synergetic manner, with a focus on inter-sectoral cooperation and partnership among those implementing the measures. Those goals are highlighted in the annual action plans, based on both strategies.
Regarding interregional health inequalities, the Health Promotion Strategy and Action Plan for Tackling Health Inequalities in the Pomurje Region was set up and provides a strategic plan that identifies the main aims and objectives for the government and other stakeholders to contribute to reducing health inequalities, as well as the strategies to reach these objectives and indicators to monitor progress [49]. The document is developed as a result of a bilateral collaboration between the Institute of Public Health Murska Sobota in Slovenia and the Flemish Institute for Health Promotion and Disease Preventions (VIGeZ), within the co-operation programme between Flanders and the Candidate Member States of Central and Eastern Europe.

The Pomurje region is the least economically developed region of Slovenia and also has the poorest health indicators, its population can be considered in general as a risk group for less favourable health compared to the population in central Slovenia. The strategic plan identifies the reduction of interregional and intraregional health inequalities in the Pomurje region as its main goal. To achieve this goal, five aims are proposed.

- The first aim refers to processes which underpin effective interventions, and is concerned especially with raising the awareness of regional stakeholders as well as the general population of the importance of health and health inequalities, and building a strong evidence base on health inequalities and health promotion.

- The second aim provides an important precondition to enable action to reduce health inequalities, and is concerned with community capacity. To increase the community capacity the following conditions must be met: a health support network, an enlarged participation of the community in decision making processes which impact health, and a change from a problem-oriented to a resources-oriented mentality. In addition, an improved capacity of professionals and lay-workers in health promotion is also important for effective health promotion interventions to tackle health inequalities.

- The third is to reduce the interregional health inequalities by developing an effective system of health promotion interventions which encourage a healthy lifestyle and social and emotional wellbeing in the region. Specific efforts to increase the early detection of non-communicable chronic diseases are also involved here.

- The fourth aim addresses intra-regional inequalities by supporting vulnerable groups like young mothers and children, dropouts, unemployed, elderly, people with special needs and ethnic minorities. For each group, specific interventions are identified to encourage a healthy lifestyle and increase their capacities for gaining independence and upward social mobility.

- The final aim focuses on a healthy physical environment. It aims to encourage environment friendly behaviour of the population, and to support environment friendly policies at the local level.

Although the strategic document is specifically designed for the Pomurje region, the strategic plan also provides a valuable input for the national strategy in the field of health inequalities.

**National Programmes:** Through the National School Nutrition Programme children in Slovenia are offered healthy meals as part of their school curricula.

The programme is running in three different schemes:

1. **All kindergartens** in Slovenia offer breakfasts, midmorning snacks, lunches and afternoon snacks. Meals are prepared or cooked in vast majority in their own kitchens.

2. Most primary schools offer breakfasts, midmorning snacks, lunches and afternoon snacks. **All primary schools** offer at least two meals (midmorning snacks and lunches) every school day. Most of them have their own kitchens financed by the Ministry of Education and Sport.
3. In 2008, the Slovene government adopted the decision to finance on healthy cooked meal in all secondary schools. These meals are offered by all schools to all secondary school students on a daily basis by different selected providers.

Scheme one and two of the National School Nutrition Programme are running since 1950 in Slovenia. All three schemes are obliged to follow the national guidelines for healthy nutrition (2005). Originally it was launched aiming to ensure that all children ate enough quantities of healthy food, but nowadays it is being used to teach them about healthy eating habits as well.

The programme is subsidized for children from lower socio-economic groups (approximately 35% of all children receive subsidized meals). The subsidies for school meals for pupils/students in 2006-2007 were: €0.55 daily per pupil, and €0.85 daily per secondary school student.

More information about this programme or other running programmes in Slovenia can be provided by:

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Spain

(Extra information was provided by the Spanish Food Safety and Nutrition Agency)

National Strategy: The Spanish Strategy for nutrition, physical activity and the prevention of obesity (NAOS strategy) was launched in 2005 and addresses obesity through different working groups. More information about this strategy can be found in the EuroHealthNet and WHO report.

National Support: The Spanish Food Safety & Nutrition Agency (Agencia Española de Seguridad Alimentaria y Nutrición – AESAN http://www.naos.aesan.msc.es) launched several actions directed to children. However, these are not specifically targeted to lower socio-economic groups but they are tried to be reached by implementing the interventions in public schools or semi-public schools. The agency has also published a guide about healthy eating directed to immigrants. This guide explains how healthy food can be prepared using local products.

National Programmes: Several activities have been undertaken as a result of the NAOS strategy. An overview of programmes can be found in the EuroHealthNet and WHO report. However, none of these national campaigns are aiming to target lower socio-economic communities.

The main project of the agency is the PERSEO intervention, which reaches almost 70 schools and more than 12,000 children. The intervention runs during 2008-09 and teaches pupils about health eating and it promotes physical activity during and after school hours. The first of an evaluation study will be available by summer. The targeted schools are all public schools and a large number are located in low socio-economic districts. More information can be found on the website: http://www.naos.aesan.msc.es.
For more information about NAOS, the Spanish Food Safety and Nutrition Agency or the PERSEO intervention, please contact:

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Sweden

(Extra information was provided by the Swedish National Institute of Public Health – EuroHealthNet member)

National Strategy: Sweden has no national action plan or a national strategy regarding the prevention of obesity. However, in 2003, the Swedish Parliament ratified the Public Health Bill, which introduced a new public health strategy focusing on the determinants of health rather than on individual diseases. The Public health policy [50] was published in 2003 and deals with physical activity as well as nutrition. The overarching aim of the policy is to create societal conditions that ensure good health, with equal terms for the entire population. Increased physical activity, good eating habits and safe foodstuffs are among the eleven target areas of the policy [52]. More information about this policy document can be found in the WHO report. It does not specifically target lower socio-economic communities.

In 2003, The Swedish Government commissioned the National Food Administration and the National Institute of Public Health to develop background material for an action plan on healthy eating habits and increased physical activity. The report was presented to the Government in 2005 [51]. It emphasizes that, in order to improve dietary habits and increase levels of physical activity, changes must be directed at the societal level, where the prerequisites for a healthy lifestyle are created. More information can be found in the WHO report.

National Support: The Swedish National Institute of Public Health has been commissioned by the government to coordinate the monitoring of eleven objective domains on the national level and is responsible for the collective monitoring of the overarching public health aim; “to create social conditions for good health, on equal terms, for the entire population”. It is also established that improving the public health of those groups most vulnerable to ill-health is particularly important.
The national public health policy uses health determinants as its starting-point to put focus on factors in both structure of society and people’s living conditions and lifestyles that are either good or bad for health. The objective domains include a number of established policy areas such as economic policy, social welfare, the labour market, agriculture, transport and the environment. Two of the objective domains; 9 – Increased physical activity; and 10 – Good eating habits and safe food; directly concern the relevant area.

**National Programmes:** In Sweden there is a focus on intersectional collaboration between the municipalities, national agencies and boards, nongovernmental organizations, etc., as well as between the national, local and regional levels. However, information provided by the Swedish National Institute of Public Health (SNIPH) revealed that programmes are running aiming to target disadvantaged communities in particular. The current programmes are running on a more structural level (e.g. city planning or school schemes); they have another approach.

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**United Kingdom**

**England**

**National Strategy:** Reducing obesity is a key priority for the Government. Since 2004, the following strategy and policy steps were taken [1]:

In July 2004, a PSA (Public Service Agreement) target specifically on obesity was set. PSAs are high level aims which set out the key improvements that the public can expect from Government expenditure. The obesity target consists in ‘halting the year-on-year rise in obesity among children aged under-11s by 2010 in the context of a broader strategy to tackle obesity in the population as a whole’.

The Department of Health published in November 2004 – in support of the PSA – the Choosing Health White Paper, which recognises reducing obesity as one of its six overarching priorities. It set the frame for action, the principles for supporting the public to have healthy lifestyles and the Government commitments in that direction [2].

Half a year later, in March 2005, the White Paper delivery Plan, together with two supporting Action Plans focusing on nutrition and physical activity set out how the White Paper commitments will be delivered. The two supporting Actions Plans were:

1. **Choosing a better diet** – a food and health action plan, which brought together all the White Paper commitments relating to food and nutrition, including cross-Government activity [3].
2. **Choosing activity** – a physical activity action plan, which brought together all commitments relating to physical activity in Choosing Health as well as other actions across government that will contribute to increasing levels of physical activity [4].
The Choosing Health progress report (May 2006) provides an update on progress of the White Paper commitments and indicates whether action on the relevant commitments have been achieved, are on track or significant was made.

The Health Challenge England – next steps for Choosing Health report, published in October 2006, presented the successes of Choosing Health and set out a Strategic Plan for delivery for the following two years.

Healthy Weight, Healthy Lives: A cross-government strategy for England (January 2008) is a policy document which outlines the government’s approach to promoting health weight in children across England. A key theme of this £372 million strategy is ‘promoting healthier food choices’, which outlines out plans to work with the food industry on a Healthy Food Code of Practice.

National Support: An example of collaboration in England is the local strategic partnerships; Primary Care Trusts (PCTs) and local authorities bring together local authorities and other public services and private, voluntary and community sector organisations to work with residents to improve local areas and services. They have a key role to play in supporting healthy eating in communities and need to ensure that they work closely on strategies to encourage access to healthy eating through local retailers, food growing schemes, cooking skills’ development, food cooperatives and community lunches. These programmes will be supported by national and regional action (e.g. the national ‘5 a day’ programme). Many examples of collaborations between PCTs and local authorities can be found in the chapter describing initiatives running on local levels.

The Cheshire and Merseyside Partnerships for Health (ChaMPs) is a public health network for primary care trusts local authorities, NHS trusts and wider organisations. The network’s mission is to build partnership to promote and protect public health and well-being, and develop capacity and capability in the public sector. ChaMPs was launched summer 2005 and by building partnerships and sharing knowledge and expertise it aims to improve the health of the population. ChaMPs is leading a campaign focusing on the prevention of obesity and health inequalities – the description of this project ‘Snack Right’ can be found in chapter four. More information about ChaMPs can be found at: http://www.champs-for-health.net.

Launched on 1 June 2004, the Big Lottery Fund is committed to bringing real improvements to communities, and to the lives of people most in need. It is responsible for giving out half the money for good causes raised by the National Lottery, resulting in a budget of about £630 million a year. The funding covers health, education, environment and charitable purposes and goes to projects and programmes within three key themes:

1. Supporting community learning and creating opportunity
2. Promoting community safety and cohesion, and
3. Promoting well-being

The fund is supporting projects and programmes in England, Scotland, Wales and Northern Ireland but has separate funding programmes for each of the countries. Several projects running on local level that are described in this report receive funding from the Big Lottery Fund. For more information, please visit http://www.biglotteryfund.org.uk.

257 innovative projects in England are funded by the Big Lottery Fund through the Health Living Alliance. This centre is co-ordinating and providing leadership for organisations delivering solutions in the voluntary and community sector that encourage healthy lifestyles and prevent ill-health. It also provides a national voice and drives forward knowledge of preventive healthcare with a view to providing high standards and consistent messages to the public.

Through encouraging people to adopt healthier lifestyles the HLA hopes to reduce and eradicate health inequality. This will be achieved by:
Identifying individual need and designing holistic health services that acknowledge the links between mental, physical and social well-being

Giving all people, especially those considered as ‘hard to reach’ equal opportunity to access appropriate health services

Providing communities and individuals access to the tools and resources they need to help themselves

Offering advocacy services to those unable or unwilling to speak for themselves

On national level, HLA is driving forward a new approach to health, and regionally it is developing networks of projects that promote and provide high quality services. Finally, on local level the HLA supports many community-based projects that enable people to make healthier choices. Examples of such projects can be found in chapter four.

For more information, please visit http://www.healthylivingalliance.org.

National Programmes: The work on obesity in England builds on existing activity but also public spending on nutrition and physical activity-related programmes. Examples of programmes can be found in the EuroHealthNet report. At the moment there are no campaigns set at national level that target disadvantaged communities while aiming to counteract obesity.

The Healthy Start Scheme is replacing the Welfare Food Scheme. After it first started in England, it is now live throughout Great Britain and Northern Ireland. The new scheme:

- Includes fresh fruit and vegetables as well as milk and infant formula milk
- Supports breastfeeding
- Encourages earlier and closer contact between health professionals and families from disadvantaged groups

- Includes free vitamin supplements for children from 6 months until their 4th birthday, and free vitamin supplements for pregnant woman and woman with babies up to one year old

Healthy Start is open to pregnant woman and families with children under the age of four who are on:

- Income support
- Income-based Jobseeker’s Allowance or
- Child Tax Credit with an income of £15,575 a year or less (2008/2009)

Once accepted on the scheme, pregnant woman and families will receive a set of vouchers through the post every four weeks. Each voucher is worth £3.00 and can be exchanged for any combination of milk, fresh fruit, fresh vegetables and infant formula milk in registered shops.

For more information, please visit http://www.healthystart.nhs.uk.

A £75 million social marketing programme was set up to help the population to make positive lifestyle changes and maintain healthy weight. This advertising campaign, called Change4Life, began on 3 January 2009 on TV, in the press, on billboards and online. In the initial stage, young families are targeted. Change4Life will make the subject of weight and physical activity a hot topic and will encourage target groups to:

- Be aware of the risk of accumulating dangerous levels of fat in their bodies and understand the health risks associated with this condition
- Reduce overall calorie intake and develop healthier eating habits. In particular by:
  - Cutting down on foods and drinks high in added sugar
  - Cutting down on foods high in fat, particularly saturated fat
  - Reducing frequency of snacking in favour of regular balanced meals
  - Eating more fruit and vegetables (increase 5-a-day habit)
Increase exercise by engaging in regular physical activity, with particular emphasis on parent/child activities and by avoiding prolonged periods of inactivity or sedentary behaviour.

The campaign is focusing primarily on families, with the objective of instigating healthier behaviours amongst their children that will serve them well as they grow up. Within this group, clusters of families have been identified who are most at risk of becoming overweight or obese - families with a lower socio-economic status being one of them. For more information, please visit: http://www.nhs.uk/Change4Life.

Scotland

(Extra information was provided by NHS Health Scotland – EuroHealthNet member – and the Scottish Grocers’ Federation)

National Strategy: In 1994, the Scotland’s Health: A Challenge to Us All – The Scottish Diet was published and it surveyed the Scottish diet, assessed the evidence for the link between diet and health and made proposals for improvement in the Scottish diet.

Two years later in 1996, a key policy document: Eating for Health: A Diet Action Plan for Scotland [35], was produced for the development of initiatives to improve the Scottish Diet. This Scottish Diet Action Plan (SDAP) was shaped by the publication in 1994, and it identified practical measures across the food supply chain to support improvement in diet. It also set out dietary targets and a number of recommendations aimed at reducing dietary related morbidity and mortality in Scotland. The key steps of this action plan are targeted on several groups, one of them being low income areas.

‘(...) Help in low income areas, through measures, co-ordinated by a national project officer funded by The Scottish Office 2, to encourage local initiatives and to improve access to a range of healthy food at reasonable prices.’

These steps are implemented in recommendations 17 and 21:

‘Supermarkets should examine, in consultation with the proposed national project officer, the feasibility of measures, such as free, or low cost, transport, to facilitate access to their stores by low income consumers within the community. They should also consider, with low income communities, the development of alternative ways in which the healthy food products available in supermarkets could be made more readily available to these communities.’

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2 The Scottish Office is pre devolution, the Scottish Executive is post devolution and the Scottish Government is the current administration
‘A national project officer should be appointed under the auspices of the Scottish Consumer Council to promote and focus dietary initiatives within low income communities and to bring these within a strategic framework. Resources should be made available by The Scottish Office to fund this post, to support innovative local projects and to sustain and extend successful, effective initiatives.’

For more information, please visit http://www.healthscotland.com.

In 2003, a wider framework for action to improve the health of people in Scotland was laid out in the Scottish Executive’s Health Improvement paper titled: Improving Health in Scotland – The Challenge (2003). This framework supported the processes required to speed up the progress of health improvement and highlighted further actions. [56].

One of the ‘challenges’ that this document summarises is the high levels of inequality in health outcomes for different socio-economic groups (for example in terms of life expectancy, rate of Coronary Heart Disease). It also emphasises the importance of following through with action by the Scottish Executive to improve life circumstances in communities by continuing tackling low income and poverty, as this will have an important impact on health. And thus one of the key conceptual stages in the next phase of work will be: ‘to increase access to healthier food choices, particularly in low income and rural areas’.

In the same year, the Scottish national strategy for physical activity Let’s make Scotland more active – was launched. It is a long term action plan (until 2022) and endorses international recommendations for the quantity and quality of physical activity required for a health benefit [57].

During 2008 the strategy was reviewed. The results of the review found no evidence to suggest that the strategy should be substantially revised and that it remains in line with physical activity guidelines issued by WHO and the EU.

However the review did highlight a number of key areas where action can be strengthened.

The strategy mentions health inequalities in its background information, and the difficulties one can face if the aim is to increase physical activity among the lower socio-economic communities.

‘Within this general picture of inactivity is a major issue of health inequality. The proportion of sedentary adults (doing 30 minutes or less of physical activity on one day a week or not at all) in the lowest socio-economic groups is double that among those from the highest socio-economic groups.’

A number of initiatives focus on areas of high deprivation, disadvantaged and hard to reach groups.

1. Paths to Health The project is a leading delivery agent for the Physical Activity Strategy. Its aim is to develop local walking schemes. Over 200 community based schemes have been supported, over two thirds of which are in deprived areas, with 1,700 Walk Leaders trained to lead walks in communities and up to 20,000 people participating in led walks every week.

2. Jogscotland The focus is to develop jogging groups in three key settings: workplaces, communities and schools/young people focusing on disadvantaged areas where possible. It has over 13,500 members in 300 groups in local communities and in workplaces.

3. Junior jogscotland programme now has over 800 Primary Schools and Youth Groups around the country already with Junior jogscotland resource packs and hundreds of children already taking part in the games based activity programme.

4. Girls on the Move aims to increase the physical activity levels of girls and young women. This initiative is a community based programme that promotes physical activity through participation and leadership programmes and focuses on girls and young women from hard to reach groups.

2 The Scottish Office is pre devolution, the Scottish Executive is post devolution and the Scottish Government is the current administration
Another strategic framework for food and health was published in 2004: *Eating for Health – Meeting the Challenge (2004)*. It is a co-ordinated action plan, developed through dialogue and discussion with partner organisations that builds upon the key actions outlined in *Improving Health in Scotland – the Challenge (2003)*.

In December 2006, the First Minister for Scotland launched the national report on health improvement activities. The document reports on progress since 2003 towards the vision for health in Scotland by 2020. As one of the next steps, the report recommends to ‘Expand on measures in low income communities through Community Food and Health Scotland and a new phase of the Scottish Grocers Federation Healthy Living Programme.’

The latest development was the publication of the ‘Healthy Eating Active Living’ action plan by the Scottish Government in June 2008, aiming to improve diet, to increase physical activity and to tackle obesity (2008-2011). The actions set out in this document are targeted mainly towards those at greatest risk of health inequalities.

One of its broad objectives is to: ‘Increase access to healthier food choices, particularly for those on low incomes and provide support, education and skill development to allow people to break through the barriers of food affordability and availability and the negative impact of culture and lack of food skills.’

In the same year, the Scottish ministerial Task Force on health inequalities published a landmark policy document: *Equally Well*. The document consists of recommendations made by the Task Force based on the latest international evidence.

The *Equally Well* implementation plan includes information on the establishment of Healthy Weight Community Projects by the Scottish Government, which aim to reduce obesity, particularly amongst children and more deprived groups of people (during 2009-2010). The projects will bring together local stakeholders to raise community-wide awareness of the importance of healthier living, and help make clearer how people can be more active in everyday life and make healthier food choices.

Also, at the end of 2008 the Scottish Government published *Good Places, Better Health*, a strategic document for environment and health that aims to identify evidence and policies that can be taken forward to create environments that promote and nurture good health. One of its first priorities in children’s health is obesity.

**National Support:** Both a Physical Activity and Health Alliance (PAHA) and a National Food and Health Alliance were launched to provide a network for those who are interested.

PAHA provides a focus for action to implement Scotland’s physical activity strategy and a national consultative platform where members share knowledge and learning and have an opportunity to inform future policy decisions for health improvement in Scotland. The Alliance has recently had its annual conference which has grown from around 200 delegates three years ago to 400 plus in 2017.

The Scottish Grocers’ Federation (SGF) is the trade association for the Scottish Convenience Store Sector. It promotes responsible community retailing and works with the Government and the media to encourage a greater understanding of the contribution convenience retailers make to Scotland’s communities. The SGF brings together retailers throughout Scotland, from most of the Scottish Co-ops, Somerfield, Spar and local independents who are the largest category of members. It is improving the supply and provision of healthier food choices, focusing on fresh produce, in local neighbourhood shops particularly in low income areas. Participating stores have registered an average increase in sales of fresh fruit and vegetables of between 20% and 30% since the
start of the programme which now boasts 550 stores representing around one million transactions per week [60].

**Community Food and Health (Scotland)** supports initiatives in low income communities which help people take up a healthy diet. It was set up as a result of the recommendations contained in the Eating for Health: a Diet Action Plan for Scotland (1996) and is funded by the Scottish Government. Community Food and Health (Scotland) is ensuring the experience, understanding and learning from local communities informs policy development and delivery through encouraging and enabling communities, policy makers and policy deliverers to have the confidence, enthusiasm and capacity to constructively engage with each other and address food access.

A total of £100,000 is distributed each year through a small grants scheme. Groups and agencies can apply for between £500 and £3000 to develop healthy eating activities with or within low income groups based in Scotland. For more information, please visit http://www.communityfoodandhealth.org.uk.

**NHS Health Scotland** is the national agency for improving the health of the Scottish population. It is a Special Health Board in NHS Scotland and is co-ordinating efforts to support delivery of the priorities for action set out in the Improving Health in Scotland – The Challenge (2003). It aims to provide leadership and work with partners to improve health and reduce health inequalities in Scotland. One of its health improvement targets is physical activity, and it supports several obesity campaigns. For more information, please visit http://www.healthscotland.com.

**National Programmes:** Several public-private partnerships have been created to promote healthy eating and physical activity through several initiatives. However, most of these initiatives are implemented at local level. Examples of national programmes can be found in the EuroHealthNet and WHO report.

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**SGF Healthy Living Programme**

The Scottish Grocers’ Federation launched the **SGF Healthy Living Programme** in 2004, which aims to provide advice on how to improve the eating habits of customers and offer a better range of healthier food options particularly fruit and vegetables. The programme is part of an extensive focus by the Scottish Government on a healthier lifestyle by the Scottish people and it is one of many programmes aimed at encouraging the population to eat healthier. There is a particular focus on children and addressing health inequalities.

An initial pilot programme ran before the programme was officially launched, whereby one store was selected from each of the five main convenience retailers in Scotland. The pilot was equally funded by the Scottish Government and each of the five main convenience retailers involved. The Scottish Grocers’ Federation was the main partner and acted as the ‘banker’ of the funds.

The project is a partnership between the Scottish Government and the retail food convenience stores in Scotland. A co-ordinator works with these retailers to discuss ways of how they can improve the range, quality and display of fruit & vegetables to encourage consumers to eat more healthily. The co-ordinator works no more than 2 days a week and is supported by 2 part time development managers who call on independent retailers to discuss the advantages of developing the fruit & vegetable category within store. Work is also being developed to bring in more “healthier for you products” from other categories.

**Aim:** The aim of the project is to improve healthy eating in community areas of Scotland – particularly within low income areas where the need is greatest.

**Support:** The programme has been funded each year from 2004 on by the Scottish Government with inward investment from the main retailers that totals
more than the sponsorship from the Scottish Government. Currently the programme is funded until June 2009.

**Trigger:** The programme was initiated by the Scottish Government through a lead person who initially worked with a major supplier within the Scottish industry and was thus having close contact with the convenience retailer. An initial meeting was set up with the retailers and the individual from the Scottish Government and agreement was reached to run a pilot.

**Targeted Communities:** Currently, 55% of the stores taking part in the programme are in low income areas. The plan has deliberately included stores within higher socio-economic areas – people who live in these areas do not necessarily eat healthy foods – particularly children and it is important to educate them as well.

**Evaluation:** The programme has been evaluated across each of it’s phases. It has shown to be very effective with over 550 retailers now having participated. Documents have been published that show evaluation of views from consumers as to whether they are eating more fruit & vegetables and whether the store does try to promote healthier foods. The retailers also give results in terms of sales increases – these have been quite spectacular with retailers who were in phase 1 of the programme still showing good growth year over year.

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### 4. Projects at Local Level

This section of the report describes examples of projects that have been implemented at local level to counteract obesity among lower socio-economic communities. The first paragraph describes initiatives that aim to counteract obesity by promoting healthy nutrition, secondly programmes are included that aim to stimulate physical activity and finally a third paragraph summarises projects that promote healthy nutrition and physical activity at the same time. It is laid out as follows:

#### 4.1 Nutrition Projects

**Belgium**
- Cheap, Healthy, Easy to Prepare and Just Tasty
- Healthy Food for Children from the ‘Bijzondere Jeugdzorg’ (BJZ)
- Healthy Food? It’s all over the place!

**England**
- Bag A Bargain
- Convenience Stores
- Cooking your way to Health
- Snack Right
- Cultivating Health

**Germany**
- Eat Healthy with Joy

**Ireland**
- Ballybane Organic Garden
- The Food and Health Project
- Growing in Confidence
- Limerick City Community Growing Project

**Netherlands**
- Healthy Nutrition Doesn’t Have to Cost Much
- SchoolGruiten

**Scotland**
- Bridgend Allotment Community Health Inclusion Project
- Edinburgh Community Food Initiative
- Janny’s Hoose Healthy Living Centre
- The Children’s Orchard

#### 4.2 Physical Activity Projects

**Austria**
- Walk Healthy – Pharmacy in Motion
- Mobility Management for Schools and Youth

**Netherlands**
- Scoring for Health
- Big!Move
- Healthy Playground
- JUMP-In
- Local Active

**Scotland**
- 60 Minute Kid

#### 4.3 Combined Projects

**Austria**
- In Shape Without Dieting
- At Your Heart’s Content – Women in Favoriten are Living a Healthy Life

**England**
- Healthy Weight for London’s Children
- Get the Balance Right: Energy In/Energy Out Campaign
- Highfield Healthy Lifestyle CIC
- Community Pharmacy Structured Weight Management Programme
- Fit4Life – Rushmoor Healthy Living
- HEAL Project
- Healthy Living Clinic
- The Chai Centre
- Irish Healthy Living Project

**Netherlands**
- The School dietician
- Healthy Weight for Migrant Women
- Equal Health, Equal Chances
- Bridging Strategy Utrecht

**Norway**
- InnaDiab Study

**Romania**
- Sibiu Project

**Scotland**
- Cambuslang and Rutherglen Community Health Initiative
- Healthy Valleys
- Inverclyde Integrated Community School

**Spain**
- DELTA Project
4.1 Nutrition Projects

Belgium

This project, set up by the Logo Zuider/Noorderkempen, is a refinement, specification and integration of already existing methods and materials focusing on healthier nutrition, but now adapted to the needs of disadvantaged groups. The Logo provides these materials and methods to 27 different communities in the region of Turnhout - Geel (province of Antwerp), where they are brought into practice.

Aim: The project aims to develop healthy and tasty nutrition habits among their target group, by focussing on the “4G’s”: Goedkoop, Gezond, Gemakkelijk en Gewoon lekker (cheap, healthy, easy to prepare and just tasty). They want to achieve this by:
1. Providing local authorities (municipalities or OCMW’s) with information about healthy nutrition guidelines (‘the active food triangle’ – figure 12)
2. Bringing these guidelines into practice in a fun and interactive way
3. Teaching the target group how to purchase and prepare healthy food
4. Encouraging the target group to join group activities (e.g. joint cooking classes).

Design: The project started on the 1st of January 2008 and runs until the 30th of June 2009. It consists of several phases:

Phase 1A: Preparation and adaptation of the materials and methods in function of disadvantaged groups.
Phase 1B: Training of project leaders (dieticians and cooks).
Phase 2: Initiation and identification of intermediates for the use of the materials and methods.
Phase 3: Running of the project. The potential participants can compose their own ‘menu of actions’ based on their individual needs and interests. They can join several activities from 5 different modules:

1. Informative presentations. This module consists of a 3 hour long meeting (including two breaks and time to ask questions). Participants can choose to follow a presentation of four different topics: a general nutrition meeting, Diabetes type II, Coronary heart diseases and the ideal weight.
2. Cooking sessions. Again, participants have the option to choose from several cooking classes, all focusing on a different recipe. One session takes three hours and they all focus on meals that you can prepare relatively easy and with cheap ingredients.
3. Guided supermarket tour. During 2.5 – 3 hours, participants are taught how to read food labels, how to compare products and how to choose and recognise the better and healthier product.
4. Budgeting. This is an informative meeting about budgeting and purchasing. Advertisements are explained, low-priced food and the rights of a consumer are discussed, and how to compare brands, packing’s and food quantities.
5. Interactive game. This game, ‘the game with the eight tables’ aims to make participants aware of the concept of a balanced diet by using eight tables and 48 accompanying benches (figure 17). Every table displays information of one of the eight groups of the ‘active nutrition triangle’ - physical activity, water, potatoes and grain products, fruit and vegetables,
milk products, fats, meat, fish, eggs and substitutes and a remainders group. The rules of the game are written on both the table and the benches. The games can either be played individually or in a group (6-10 persons). It takes around 80 minutes to play the games of all the tables.

At last, a brochure with the title: ‘Dieting: a luxury or a necessity?’ was developed and can be ordered by the participants as well.

The Logo Zuider/Noorderkempen will make municipalities or local authorities aware of the project. After they have showed their interest, the Logo provides them with the available materials and methods. The organisation and logistics of the actual events are the responsibility of the municipalities and local authorities, and the OCMW’s have to recruit the participants. The activities will be guided by the dieticians and cooks, who will be present when the events take place.

The applicant of the project (local authority, OCMW and/or a local organisation) is responsible for the finances of the programme. The implementation costs are 30 euro’s per module, and 40 euro’s per module when more than six different courses are chosen. The travel costs of the dietician or cook will then have to be reimbursed by the applicant as well. Some local authorities or OCMW’s ask the participants of the programme to make a small contribution themselves. Reason for this is not only to spread the costs, but also to motivate them to actively participate and engage to the project.

Support: Apart from the Logo Zuider/Noorderkempen, parties involved in this project are: the Koning Boudewijnstichting, Vormingsplus Kempen, Centrum voor Basiseducatie, participating OCMW committees, dieticians in the arrondissement Turnhout and one cook.

The total budget of the project is €14.700. Apart from its own contribution, Logo Zuider/Noorderkempen gets its financial support from the Koning Boudewijnstichting, Vormingsplus Kempen and the participating OCMW committees.

Trigger: The project was initiated by local authorities and the OCMW’s involved.

Targeted Communities: The project specifically targets the lower socio-economic communities in the municipalities described above.

Evaluation: A provisional evaluation will take place during January 2009, and an end evaluation will follow during autumn that year.

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Figure 17: ‘Game with the table and accompanying benches’
Source: Logo Zuider/Noorderkempen
This new initiative aims to develop a method for introducing healthy eating habits to children and youngsters from the ‘Bijzondere Jeugdzorg’ (BJZ) and their communities. BJZ is a child protection organisation for children who are in conflict with the law or children in need of care and protection.

**Aim:** The project aims to modify the food habits of children from ‘Bijzondere Jeugdzorg’ (special youth care) by offering them healthier food choices. This will be achieved by:

- Change the nutrition content that is offered by BJZ to the children. By training the cooks of BJZ, healthier food will be prepared.
- Give healthy and tasty food workshops to the educators-coaches and directors
- Provide healthy and tasty food workshops and games for the children and their parents

Ultimately the goal is to measure if these interventions have a positive influence on the behaviour and the mood of the children. This might be studied through a doctorate study with the KUL (Catholic University of Leuven) - this possibility in still under consideration.

Not only does this project aim to obtain a better physical health, but also to improve mental health and wellbeing by healthy food habits.

**Design:** The project was initiated by Marie-Laure Prevost, lecturer of Nutrition at the Erasmus Hogeschool Brussels. It is a new initiative, which started in September 2008. It is currently in the pilot phase where the relevance of the approach and the trainings with the targeted communities are being tested. The pilot phase started with three different workshops for the cooks of seven organizations of the JBZ in the region Brussels-Halle-Vilvoorde.

**Support:** The project is financially supported by the Erasmus Hogeschool Brussels in the form of a Scientific Research Program (PWO projector ‘Project Wetenschappelijk Onderzoek – Project Scientific Research’). This means that two lecturers from the school will receive the task to work on this project from September 2008 until September 2011. Other financial support comes from Full Spoon VZW, who received funding for this project from the Koning Boudewijnstichting. The trainings in the pilot phase were giving with the support of Logo Brussels and COOVI (cooking school).

**Trigger:** Committee ‘Bijzondere Jeugdzorg’ (special youth care) and Logo Brussels started inquiring about the living habits inside of the organisations in 2006-2007. Based on the results of this inquiry and the demand of the organisations of the BJZ, the project started.

**Targeted Communities:** Research confirms that people with a low socio-economic status have more health related problems, linked to food habits, which can be deducted by their higher BMI’s. The children from the Bijzondere Jeugdzorg are almost all from communities with a lower socio-economic status. By targeting those children, the project wants to break the vicious circle by preventing them from developing into ‘unhealthy’ adults.

**Evaluation:** The project is still in the pilot phase so there are no scientific evaluations yet at this stage.

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This project, set up by a Flemish women association – VIVA-SVV – aims to introduce persons from deprived areas in Flanders to preventive healthcare by offering them a health care course. Ultimately, these persons will become contact points – health ambassadors - in their neighbourhood.

Aim: The project aims to offer a health education course to persons from deprived areas. These persons will hopefully pass their knowledge on to others living in the same neighbourhood, eventually leading an area where persons are living their life in a healthier way.

Design: ‘Healthy Food? It’s all over the place!’ is a project set up for, and together with, persons from deprived areas. The VIVA-SVV – a women association in Flanders – works together with a meeting centre (‘Open Huis’) in the middle of a deprived neighbourhood, to give lower socio-economic groups a one year health care course. After this, these persons become contact points for questions about health in their neighbourhood. They don’t serve as doctors, but they are able to give advice and information.

Also, ‘healthy vegetable recipes’ were made and are distributed among visitors of the food bank – an event that takes place at the ‘Open Huis’ meeting centre. Here, persons learn how to cook healthier and the importance of using vegetables.

At the moment the project is still in its pilot phase. During one year, twelve courses are given followed by an examination. So far twelve persons have participated.

Support: The project is receiving financial support from the King Baudouin Foundation and the National Lottery Fund. Also, VIVA-SVV, the ‘Open Huis’ meeting centre and health insurance company ‘De VoorZorg’ use a part of their own budget to finance the costs.

Besides the educational team of VIVA-SVV, a physical therapist, a dietician and two social workers are involved in the project.

Trigger: VIVA-SVV identified insufficient knowledge among their members about health related issues such as blood pressure, the importance of calcium intake etc. After discussing this with the social workers of the ‘Open Huis’ meeting centre, it was decided to launch a pilot of the programme.

Targeted Communities: The project targets persons living in areas of deprivation in Flanders. They are directly targeted, as the project is running in the middle of their neighbourhood.

Evaluation: The pilot phase of the project will be evaluated in January 2009. However, persons already indicated that they cook healthier more often, pay more attention to their cholesterol levels and blood pressure levels and are more physically active.

The project will continue running on the organisation’s own budget, and is planned to be implemented in another deprived area in Flanders as well.

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Bag A Bargain

The Bag A Bargain initiative supports people to eat healthily by offering local communities the opportunity to buy cheaper locally grown fruit and vegetables. The project offers low-cost fruit, vegetables and salad for sale at convenient locations in targeted neighbourhoods. Products are delivered to one fixed location and then distributed over several venues. The project is run largely by members of the community - from delivery to distribution.

**Aim:** The Bag A Bargain initiative supports people in deprived areas of Wirral (close by Liverpool) to eat healthier by offering them a bag full of locally grown fruit, vegetables or salad for a low-cost.

**Design:** This is a project entirely run by members of the community of Wirral, since October 2006. The fruit, vegetables and salads are delivered in crates at one fixed location (Tranmere), where they are bagged by volunteers and then distributed over the multiple venues (churches, schools and community centres) by the residents. The food can be bought for £2.50 a bag.

The majority of food comes from a local Wholesaler. For the first 18 months of the project this was Redbridge, who bought from Liverpool Market. However, following feedback from service users regarding quality, they now use Farm Fresh Supplies, a wholesaler based in North Wales. Although Farm Fresh supplies the majority of the produce, a local allotment scheme often provide seasonal produce that they have grown, although this is ‘top-up’ the bag and add more value to it.

The number of persons working on the project differs all the time, but there is always one separate lead from each venue. Of these leads, some are voluntary as they are churches/community venues and some are based in schools and children’s centres that will have paid staff who lead on this as part of their health promoting role. There are only two staff members who are directly paid through the project funding, and these act as Project Managers. There are approximately another five to six volunteers who work between venues, taking money, banking money, and bagging up the produce when it is delivered on a morning. There isn’t anyone from NHS Wirral who works on the project on a daily/weekly basis.

To promote Bag A Bargain, persons use the local press and local organizations. However, spread by word of mouth by residents seems to be the most efficient way. Furthermore they organized a ‘freebee week’ when they first started with the initiative. If people bought a bag and ordered one for the following week as well, they got one bag for free.

Figure 18: Left: Fruit bag. Right: vegetable bag  
Source: Wirral Primary Care Trust
Bag A Bargain is also part of the Healthy Start Scheme, which means that Healthy Start Vouchers can be exchanged for bags of fruit, vegetables or salad at any of the ‘Bag a Bargain’ venues.

**Support:** The initiative is financially supported by the lottery funding. This money is used to stock the products and to purchase the bags needed for distribution.

Bag A Bargain was set up as part of the ‘Together’ Project (short for Together Neighbourhood Management Project), which is led by NHS Wirral and the Riverside Group in partnership with residents.

**Trigger:** The lack of provision to fresh, quality fruit and vegetables at a reduced price inspired the local residents to start with this initiative. They contacted NHS Wirral in October 2006 to help addressing this issue by starting with this project.

**Targeted Communities:** The initiative originally operated out of three venues in Wirral. But as it turned out to be a success, the numbers of venues selling the products have nowadays grown to at least nine, and have expanded into other neighbourhoods and schools all across Wirral.

**Evaluation:** The initiative seems to be a success, as the turnover raised during the first six months from 150 bags a week to 400 bags a week. However, the organizers nowadays see a decline in the amount of bags they sell, which is probably due to the general economic crisis. At the moment they are selling around 200-250 bags a week, and they are therefore considering the possibility of starting to sell small bags of £1,-, to attract more persons.

In 2008, the initiative was joint winner of the Best Practice in Community Involvement Award. This is an award voted by local partners (PCT, Local Authority, residents, etc) on local projects.

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Convenience Stores is a joint initiative by DH and the Association of Convenience Stores to promote healthy eating. The project was launched in the North East in November 2008, where stores in low-income areas have received funding to improve the availability and sales of fruit and vegetables. The programme is part of the Change4Life movement.

**Aim:** The programme will contribute to the national commitment:

*Halt the year-on-year rise in obesity among children under 11 by 2010, in the context of a broader strategy to tackle obesity in the population as a whole (2004 Government PSA target).*

To achieve this, the programme aims to:

- increase the consumption of healthy foods (particularly fruit and vegetables), and
- to rebalance marketing, promotion, advertising and point of sale placement, so that there is a reduction of exposure of children to the promotion of foods that are high in fat, salt or sugar, and an increase in the exposure to the promotion of healthy options

**Design:** To get the programme underway, twelve ‘development stores’ were launched in November 2008 which showcases a range of initiatives to promote fruit and vegetables. The aim of these development stores is to trial the best initiatives, and to recruit other retailers to the programme. The stores were provided with new chillers, stands and other display items to stock their extended range of fruit and vegetables. The retailers have been encouraged to tie in health initiatives in their communities; this has included advertising free cookery clubs, and sponsoring a local football team.

Shop staff will be offered training in nutrition so that they can pass on knowledge about the health benefits of fruit and vegetables to customers. They will also receive training on the best way to stock and sell the produce to minimise waste.

The programme launch coincided with the launch of Change4Life in the region. The programme aims to have 120 participating stores in the North East by May 2009, which will be recruited by a steering group and project team of main symbol groups (Spar, Costcutter, etc).

**Support:** The Convenience Store programme forms part of the Change4Life movement; a £75 million social marketing programme to help us all make positive lifestyle changes and maintain a healthy weight.

The Department of Health (DH) will be providing £800,000 over three years from 2008/9 to 2010/11. The convenience store programme is working in partnership with the Association of Convenience Stores (ACS), and these have agreed to match DH funding to the project.

**Trigger:** The initiative is based on a similar scheme in Scotland. The Scottish scheme, which started with 10 stores in 2004 and has now more than 500 on board, has seen participating shops benefit from an increase in profits – anything from 20 per cent to 400 per cent on fruit and vegetables. In all focus stores, a 28% increase in fruit and vegetables was experienced.

**Targeted Communities:** Convenience stores in low-income areas in the North East, where there is relatively poor access to fruit and vegetable, will have the opportunity to participate. The Symbol Groups were asked to nominate candidate stores in low income areas as a priority.

Storeowners will receive fruit and vegetable stands, Change4Life promotional materials and expert advice on marketing to encourage the local population to
eat more healthily. Some stores will also receive a financial contribution toward the cost of a new fruit and vegetable chiller cabinet.

A project co-ordinator will work with the stores to help them to maximise profits and minimise waste. The co-ordinator will also help retailers tie in with local initiatives such as nutrition training and cookery clubs.

**Evaluation:** Initial sales data show that sales of fruit and vegetables have increased by between 30 - 300% in every development store so far. An executive evaluation report will be available from January 2009 on.

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Cooking Your Way to Health

Cooking Your Way to Health is a programme to address health inequalities and improve healthy eating awareness via several ‘Grab 5!’ activities. These activities are run by club leaders for 7-11 year olds in 14 different primary schools in Ealing Borough.

Aim: This project aims to:
- promote healthy eating by teaching practical ways to adapt familiar meals to increase fruit and vegetable consumption and reduce fat, sugar and salt intake,
- deliver culturally sensitive healthy eating messages to hard to engage groups,
- increase knowledge of the benefits of healthy cooking and eating to schools and community groups of all ages,
- provide training and employment opportunities for members of the local community (Cookery Club Leaders), and to
- improve social cohesion in the community and reduce isolation

Design: This programme has developed several community based food projects to address health inequalities and improve healthy eating awareness. These activities include:
- Cookery Clubs
- Grab 5 workshops for children
- Grab 5 parents talks
- Healthy eating assemblies
- Health Fairs
- Healthy tuckshops
- Grab 5 parents talk
- Healthy eating displays and demonstrations in local businesses, at Ealing PCT health promotion events and in local pharmacies.

With these activities it also improves the knowledge of the target group of how food can affect health and helping people to make realistic improvements to their diet taking into account their potential barriers to change e.g. socio-economic factors, knowledge and skills.

Targeted Communities: This programme targets children and teenagers, groups at high risk of obesity, CHD and diabetes, socially and economically deprived groups, and adult groups at risk of malnutrition e.g. young mothers, elderly people.

Evaluation: Grab 5 was evaluated as a research project through WelRen study: ‘Do physical activity and nutrition schemes work for children in Ealing’?

Cooking your way to Health, primary evaluation showed that clubs were effective and sustainable, thus the project funding has been extended through Choosing Health funding until March 2007.

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The Snack Right campaign, led by the national ChaMPs Public Health Network, supports parents and carers of pre-school children living in deprived areas of Cheshire and Merseyside (North West of England) to replace at least one unhealthy snack a day in their child’s diet with a healthy one.

**Aim:** The goal of this initiative is to increase the proportion of children eating at least one fruit or vegetable snack more than prior to the campaign. The project does not only focus on changing the food (snacking) habits of the children, but it also tries to change the knowledge and attitudes of the parents and carers of the child.

**Design:** The Snack Right initiative is an example of social marketing and consists of several phases.

**Scoping Phase; Partnerships and Funding.** The first phase of the initiative - the scoping stage - was set up to gain insight into the target audience and their purchasing behaviour. The results of the scoping stage revealed that an important factor that can influence a family’s purchasing decisions was big-brand advertising, since people easily recall specific advertisements and associated characters that appeal to children. The campaign thus needed to wield the same power as the brands that were selling less healthy food. It needed a strong and recognizable identity, and partnership – particularly with retailers - would be vital.

After mapping all possible partners (low budget supermarkets) and studying (Mosaic) consumer profiles, food retailer Aldi was chosen as a retail partner in phase one. The supermarket chain had shops in the right geographic areas, it appealed to the target audience, it had a local supply policy on fresh products and it had signed up to the Government’s Healthy Start scheme.

**Development Phase; Testing and Refining.** During the development stage, the Snack Right brand was developed and the messages of the campaign were stated. A number of factors affecting behaviour around healthy eating choices were set up. These included:

- **Barriers** to healthy eating - a “can’t cook, won’t cook” attitude; a lack of basic knowledge around nutrition; a belief healthy food was expensive food; preparing healthy food was time-consuming and inconvenient; children were likely to reject it and budgets were too tight to waste food
- **Influencers** of healthy eating - children’s centre/nursery workers (generally positive); retailers (often negative at the time); media (both negative and positive)
- **Motivators** – retail offers (voucher promotions, product placement; positive messages at point of sale); pester power of children
- A belief some junk foods led to hyperactivity

Research showed that the negative behaviour could be challenged if an intervention captured the following:

- Healthy snacks benefit long and short-term health
- Fruit and vegetables aren’t expensive
- Healthy snacks can be quick and easy to prepare
- Early food preferences stay with you for life
- Healthy snacks can improve kids’ behaviour
- Slow release snacks keep child energised longer

It was agreed that snacking should be the focus of the intervention. The key behaviour goal would be for children aged 3 from deprived neighbourhoods to
“replace at least one unhealthy snack each day with a healthy one”. Ideally, this would be a fruit or vegetable. Furthermore, six other, secondary, goals were agreed:

1. Parents and carers would attend a Snack Right event with their children
2. Parents and carers attending Snack Right events would overcome negative perceptions of fruit and vegetables as a snack food for children
3. Every child would have the opportunity to try fruit and vegetables snacks at the events
4. Children would continue to “snack right” through the work of ambassadors (see below), primary care trusts, local authorities, communities, etc.
5. Ambassadors were engaged in the process and attend Snack Right events
6. Ambassadors delivered their own events

A network of 150 Snack Right "ambassadors" was recruited to organise events. The ambassadors - who ensured delivery was locally-led and tailored to local needs - include obesity leads, children’s centre managers, health visitors, health promotion workers, health trainers and community cooks. There are two types of ambassadors:

Strategic ambassadors (a third of the total amount of ambassadors) supported local plans for delivery of Snack Right and provided staff to support the implementation, including events and passing on messages to target groups. They also worked to embed the Snack Right model through local strategic plans or work plans, and create a legacy for the project.

Tactical ambassadors delivered Snack Right messages, promoted and delivered events, supported the delivery of events, and sustain messages with the families they work with.

The project was delivered in two phases – the first in spring/summer 2007 and the second in summer/early autumn 2008.

During the first phase of Snack Right a marketing mixture was used. Leaflets promoting healthy snacking were distributed to targeted households via a door-drop to 113,000 families. Secondly, a media campaign in local and regional papers, on radio and a website was used to communicate key messages to parents, carers and the wider community. Finally, fifteen fun Snack Right events were held, mainly at local authority children’s centres. These were aimed at children but, crucially, were an opportunity to engage with the parents or carers who accompanied them. They were provided with information about the short and long-term health benefits of replacing an unhealthy snack with a healthy
one. Giving them information on a one-to-one basis was essential because of low literacy and numeracy in the target families.

Besides focusing on the encouragement of the intake of fresh fruits and vegetables, the events also promoted the take-up of Healthy Start vouchers. This is a national food voucher scheme worth up to £5.60 a week for low-income families.

In the second phases of the campaign, the age range for the project was change to children aged six months to four. This reflected the advice of health professionals and the recognition food preferences started to form before aged three. Between June and September 2008, forty-nine further events were organized with an emphasis on sustaining Snack Right into the home. This was done through a direct marketing campaign underpinned by the Snack Right 5: a group of fruit and vegetable cartoon characters. Furthermore, legacy materials were developed like folders, books and poster.

The events themselves were similar to phase one but with more interactive games using fruit and vegetables, and two life-size versions of two of the Snack Right characters – Pip the Apple and Narna the Banana – were commissioned to attend the events. The events consisted of tasting sessions and games (e.g. making your own fruit face) to give young children the chance to try healthier options. The key difference was professionally photographing each child who attended with parental consent. The photograph was later mailed to their home with a letter and snacking sticker calendar. Children who completed the calendar were mailed a wipe-clean tablemat as a reward. Their parents/carers were also entered into two prize draws and they received other communications such as a recipe for a fruit snack.

**Support:** The project started a boundary-spanning partnership with health (e.g. public health practitioners), local authority (e.g. children’s centre manager), communications and Third Sector (e.g. Heart of Mersey charity) professionals. It was facilitated by ChaMPs Public Health Network, which works in partnership across Cheshire and Merseyside to promote and protect public health and well-being, and builds capacity and capability across the public sector. By using this diverse partnership, it enabled the campaign to use a mixture of channels to reach its target audience.

The campaign was funded with £263,000 from the Department of Health Communities for Health Fund and commissioned by Cheshire and Merseyside’s directors of public health, who also contributed £50,000.

**Trigger:** The ChaMPs social marketing group identified that although much was being done in deprived areas of Cheshire and Merseyside to address health inequalities, there were gaps in services for pre-school children. Children’s centre workers told them during interviews that children generally ate well in day care but were given “junk” snacks as their parents/carers took them home.

**Targeted Communities:** The campaign focuses on this target group, because:

- there is proportionally less health advice available for this group compared to babies and school-age children
- this is the age at which food tastes are formed for life
- Cheshire and Merseyside has some of the worst health inequalities in England
**Evaluation:** The Healthy Start statistical report showed that a significant increase in the number of applications for the Healthy Start vouchers during the first phase of the campaign.

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>No of applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>14th May – 10th June 2007</td>
<td>241</td>
</tr>
<tr>
<td>11th June – 8th July 2007</td>
<td>308</td>
</tr>
<tr>
<td>9th July – 5th August 2007</td>
<td>210</td>
</tr>
</tbody>
</table>

An evaluation of phase one was conducted by Liverpool John Moores University. Their findings and observations in the field of how phase one was received, were used to re-scope and develop phase two. The phase one evaluation demonstrated recognition of Snack Right in the target audience and awareness of healthy snacking. Researchers noted the challenge of isolating Snack Right from the “background noise” of other healthy messages.

In phase two, additional insight and customer understanding led the social marketing group to:

- Extend the target age range to include children aged six months to four because tastes and preferences, and parental choice, were already apparent
- Overhaul and expand marketing materials – paper-based resources (e.g. leaflets) would be improved but augmented with practical, durable products that stay in the home as prompts to healthy eating
- A direct marketing intervention would be developed based around each child being professionally photographed at the events. (In phase one, parents had been interested in receiving copies of photographs for the media we commissioned, although we didn’t supply this service.)
- Mailing the photograph to the child’s home would sustain Snack Right and the behavioural change it encouraged into the home

A more robust baseline was established for phase two evaluation and will report in early 2009. But quantitative outcomes showed that by autumn 2008:

- **Participation.** 3,788 children, parents and carers attended 64 Snack Right events from the targeted groups, including black, ethnic and migrant groups
- **Direct marketing.** 1,003 children – made up of 894 families - were signed up to the direct mail programme. 41% took part in the competition and continued replacing an unhealthy snack with a healthy snack for at least four weeks after attending an event
- **Healthy Start.** Applications for Healthy Start vouchers in the Merseyside area increased by 25% during phase 1 of Snack Right. In phase 2, 46 families signed up to Healthy Start at events with many more joining afterwards
- **Families’ views.** 84% of families attending phase 2 events felt they had picked up tips about healthy snacking

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Cultivating Health is creating partnerships with local agencies, aiming to promote local horticulture. At the moment the project is in its infancy but is hoped to be launched on 1st March 2009.

**Aim:** The aim of the Cultivating Health Project is to promote local horticulture and provide more healthy lifestyles of local people.

**Design:** Cultivating Health involves partnering local people to grow fruit and vegetables in domestic gardens which are currently not being maintained, especially where elderly residents no longer have the mobility to carry out the work involved. The project will recruit families and those with mental or physical health needs without gardens and provide them with the skills to grow their own produce and partner them with a local person with a garden suitable for growing vegetables and fruit.

Cultivating Health is creating partnerships with local agencies such as local health centres, job centres, health support groups, Sure start, etc. who will refer people to the project.

Individuals are assessed for their capabilities, needs and training requirements, where necessary with the input of their carers. The Project is a valuable health intervention within an overall model for social health prescribing, involving a range of therapies and practical activities. The benefits are many; improved access to fresh, home grown fruit and vegetables, the establishment of partnerships and social networks which ease isolation, improved physical activity levels for partnerships, training in basic horticultural skills and the resources of trained professionals for guidance and support.

The project is in its infancy but is hoped to be launched on 1st March and has plans for it to be an ongoing project for at least three years.

**Support:** The financial support for Cultivating Health was secured by the Bacup Consortium Trust, from the local PCT in the form of a successful bid under Community, Voluntary Faith Sector and Statutory Agencies. The funding so far has been used to employ a part-time project officer and to resource the project initially in the first year. Other Parties who have expressed a committed interest in becoming involved are: Age Concern, Green Vale Housing, Calico Housing, Rubicon, Sure Start, Burnley Food Links, Local Primary and Secondary Schools, Ewood Day care and the Community Department of Rossendale Council.

**Trigger:** The original idea was by a member of the Bacup Consortium who was aware of the amount of gardens not being fully utilized and the increasingly large waiting lists for allotments in the local area. Her dream was to see vegetables being cultivated in and around Bacup by the local community who would most benefit from nutritious, fresh local produce.

**Targeted Communities:** The main target group is the elderly and those with mental health issues or those who have faced unemployment for some time. Even though individuals with a higher socio-economic status are not part of the target group, the emphasis of the project is to promote healthy eating and living community wide.

**Evaluation:** As this project is as yet in its early stages, there is no evaluation material ready to publish. However, it is included in the project Outline that evaluations and data will be analyzed and published where appropriate.

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Eat Healthy with Joy
(Gesund essen mit Freude)

This is a project initiated by ‘Gesundheit Berlin e.V.’, a health promoting registered charity. It aims to change eating habits of Turkish children to a healthier option, both through their parents’ home and through their school environment.

**Aim:** The aim of the project was to convey healthy eating habits to Turkish children through their parents’ home while recognizing cultural habits. The course was carried out in close collaboration with the school so that a second aim was to create a health-promoting school environment.

**Design:** The general approach was setting orientated, via neighbourhoods and schools in the local area. Nutritionists, social workers, youth workers and teachers acted as multipliers, and a co-operation with a popular Turkish TV-station was established.

The course design differs from conventional teaching (“We show you how to do it!”) which was reduced to some background information on nutrition and mainly focused on team teaching elements (“Let’s see what the group knows!”). As the settings were carefully chosen, the targeted groups were indeed reached. In cooperation with the social worker and the school directors, the school where the project took place provided an area where mothers were given the opportunity to share their personal experiences, e.g. cultural perception of food, eating or cooking habits.

Beyond the intervention goal of improving eating habits of the families the setting lead to participants acting jointly. Project leaders describe this aspect as basic for the success of the intervention: the common activities of the women had, in turn, positive effects on the social structures of the school where the project took place. Gradually participants were in contact with school workers, while they had not done this before due to the lack of German language knowledge. For the first time the Turkish mothers took part in a school party celebrating the inauguration of a new playground.

The initial phase started in September 2004 and finished in July 2005.

Nowadays there is such a high demand that the intervention has expanded from a local initiative to a federal wide one, four editions of the cookbook have been produced and in 2009 the BKK re-launches the cookbook and the course material.

**Support:** Partners of this project are the Federal association of health insurance companies (BKK), Ministry of consumption (auspices), Turkish ambassador, Turkish TV channel TD.

Gesundheit Berlin e.V. is a health promoting registered charity with a long history of successful and innovative pilot projects in the fields of health promotion and setting orientated approaches especially for socially excluded people.

**Trigger:** Turkish children have an above average tendency to suffer from obesity; this is documented by school enrolment medical examinations. In adult age, these persons suffer more often from coronary heart and other diseases. Healthy nutrition during childhood can prevent these. While conventional measures to improve nutrition in the Turkish population haven’t been very successful, especially due to language barriers, this intervention was created that explicitly integrates Turkish culture and tradition.
**Targeted Communities:** In general, young adults (19-29 years), adults (30-59 years), persons with a relatively low socio-economic status, as measured by education (e.g. secondary school degree, school drop-out) income (e.g. below average income, on social benefits) and migrants (e.g. asylum seekers, immigrants) belong to the target group.

Since Turkish mothers play a key role in the nutrition of their families, they are approached as multipliers. In discussion groups and cooking courses they were introduced to healthy cooking.

Through these measures Turkish mothers did not only serve as a target group for opening access for health promotion into families with a Turkish migration background but also widened the scope of these women in other matters: By cooking together the groups developed further social adhesion and indeed the measure can also be termed successful under the aspect of community building.

**Evaluation:** The intervention was rated as very positive so that a bilingual cookbook and a course manual have been developed that leads to spreading the intervention to other Turkish communities.

Internal evaluation exists: participant-oriented assessment by questionnaire. External evaluation was carried out by Team Gesundheit, an organisation which collaborates with Duisburg university for evaluation in the area of health promotion.

The project has been identified as “Good Practice” in the fields of “innovation and sustainability”, “setting approach” and “participation” by the Kooperationsverbund “Gesundheitsförderung bei sozial Benachteiligten”, a German network of more than 50 organisations supporting health promotion for socially disadvantaged people.

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This is a partnership project, aiming to teach persons from the most disadvantaged areas of the country about organic gardening processes and healthy eating. It also provides nutritional education and cooking skills.

**Aim:** The aim of the project is to provide a supportive environment where participants from the local area can learn about the organic gardening processes and healthy eating. Advice and information are given at each stage from growing through to harvesting. Examples of foods been grown include potatoes, corn, lettuce, tomatoes, scallions, coriander and runner beans.

In addition, the Community Nutrition Department (HSE West) and Home Management Department (HSE West) provide nutritional education and cooking skills as part of the overall learning process of the project.

**Design:** The Ballybane Organic Garden was set up in March 2006. The garden is continually developing and expanding. In the first year there was one morning a week session with the gardener. This has been expanded to one morning and one evening to facilitate others to participate. Future plans for the garden include developing a composting scheme to involve people in the wider community.

In addition the garden is been extended to facilitate access and usage for a great number of people. City Council has provided extra land to develop an orchard, have more vegetable plots, develop a play area and put in a clay oven and BBQ.

Key target groups are being expanded through engagement with the local crèche and also an older person’s day centre located near the garden.

The promotion and recruitment of participants in the local community is ongoing through local newsletters and also the celebration of work through an annual Harvest Day.

**Support:** It is a partnership project between Galway City Council, Health Service Executive West, Ballybane Community Development Project, City of Galway Vocational Education Committee, Ballybane Community and RAPID.

The RAPID (Revitalising Areas through Planning, Investment and Development) programme specifically targets the most disadvantaged areas of the country and it is intended that these areas should receive prioritised investment and development by central government departments. The programme is delivered locally by a multi-disciplinary team – An Area Implementation Team (AIT).

Funding on a yearly basis is provided through the Health Service Executive West Health Promotion Department, RAPID and City of Galway Vocational Education Committee as there are community, education and health benefits. This was the first community organic garden project in Galway City. Community garden projects have since been set up in two other RAPID areas based on the success of the Ballybane project.

**Trigger:** Health Promotion Services of the HSE became aware of the potential for such a project in Galway City following learning about the experiences of a similar project in the North West of Ireland. In 2005 Health Promotion approached the Galway City Rapid group who were very interested in supporting this initiative. Following a presentation from Health Promotion Services it was agreed that such an initiative would be piloted in one of the Rapid areas and it
was agreed that Ballybane would be a suitable location. Following on from this, the Community Development project in the area were approached by the Health Promotion Services HSE West which is the lead partner of the Galway Healthy Cities Forum and ideas to progress the project were explored. A small steering group was set up and work commenced on establishing the Ballybane Community Organic Project.

Targeted Communities: The target group is lower socio-economic groups and this is achieved through focusing on RAPID areas in the City. The programme is delivered to areas including Galway City Council, State Agencies, Galway City Partnership, and residents’ representatives from each of the five RAPID areas – Ballybane, Ballinfoile, New Mervue, Bohermore and Westside. It is implemented locally through the RAPID Co-ordinator, Galway City Council.

Evaluation: An evaluation was completed after at the end of 2007. The evaluation found that the project has developed a new and different community facility or resource and is a major infrastructural enhancement to the local area. The garden is being used as a catalyst for community development activities for local men’s group and older people’s day centre located across the road. It promotes healthy lifestyles through outdoor exercise, learning about growing their own vegetables and also cooking and nutrition classes. The garden is also a community point providing an informal space for local people to meet and socialize through gardening. Finally, it was found that the key success of the garden is built on the partnerships of all involved engaging with the local community.

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This project targets communities from areas of deprivation in the Midlands of Ireland and provides them with practical information about healthy nutrition. The disadvantaged groups were selected by using a screener form.

**Aim:** The overall aim is to improve the access of low income groups in the Midlands of Ireland to good quality practical information about healthy eating.

**Design:** Healthy Food Made Easy, a training pack for use with peer instructors was first developed in Dublin as a pilot program. The Department of Health and Children then produced the program for use throughout Ireland. In the Midlands, the project was first started in 1999. The Midland Health Board funded a community dietician with a remit for disadvantaged groups. The first Food and Health project was set up in 1999 as a joint initiative between the Health Service Executive, Dublin Mid Lenister (HSE DML) and the Westmeath Community Development (WCD). Initially the project trained peer instructors to facilitate the Healthy Food Made Easy program to groups in counties Longford/Westmeath and North Offaly. In 2003, funding became available and a second Food and Health project was set up in partnership with the Mountmellick Development Association. Therefore at present the Athlone project covers Counties Longford and Westmeath; with Mountmellick covering counties Laois and Offaly (and Kildare although this is only since 2007).

Other programs have been developed for use with other disadvantaged groups who could not access the Healthy Food Made Easy program. Cooking for Health was developed as a more practical program which is facilitated by the instructors to groups with learning difficulties or attention span issues. The Cool Dude Food program was developed for use with children’s groups.

**Support:** The majority of funding is received from HSE DML; however each participating group makes a contribution towards the costs of the course. Funding is also sought from other organisation via grants etc. The aim is that 25% of funding is non-HSE.

**Trigger:** Evidence would suggest that there is a poorer diet in people experiencing poverty – the Food and Health project was set up to address this issue.

**Targeted Communities:** The Midlands of Ireland is largely a rural area. Geographical indices could not be used to determine that the participant would be disadvantaged, thus a screener form (adapted from one used by Nelson et al 2003) was used. Each group fills in the screener form – this form asks re material deprivation indices; we have also included questions on ethnicity and education. If a person shows 3 or more indices of material deprivation they are deemed to be disadvantaged; if a group has 70% or more people in their group scoring 3 or more.

**Evaluation:** Participants attending programs fill in an end of course evaluation form. In an effort to improve on the quality of feedback from groups in 2009, we will be carrying out focus group testing on at least 10% of the groups attending the Healthy Food Made Easy course.

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**Growing in Confidence**
http://www.theorganiccentre.ie/community_food_project

Growing in Confidence is a community food project in the North West of Ireland, which recognises the need to promote healthy food production and healthy eating as a means of reducing health risks and as a means of improving quality of life for members of local communities.

**Aim:** The aim of the project is to increase knowledge, awareness and skills among target groups in relation to fruit and vegetable production, preparation and consumption and to promote positive health and well-being. The specific objectives are to:

- improve participants’ knowledge of and skills in relation to vegetable and fruit growing
- enhance participants’ skills in preparing and cooking fruit and vegetables
- increase participants’ consumption of fruit and vegetables
- increase participants’ knowledge of the nutritional value of fruit and vegetables
- develop more positive attitudes towards consumption of fruit and vegetables
- provide opportunities for physical activity outdoors
- provide opportunities for positive social interaction and development

**Design:** This project seeks to improve the access of people on a tight budget to fresh fruit and vegetables, by encouraging and helping them to become involved in growing their own, organically. In cooperation with local agencies and community groups, participants were recruited in Sligo town and in rural Leitrim, and were given the opportunity to meet regularly with professional and experienced gardeners from the Organic Centre.

The project consisted of weekly or fortnightly organic gardening sessions, on plots provided by the Organic Centre and by the St Michael’s Family Life Centre in Sligo. This was backed up by some classroom instruction in gardening techniques and knowledge and by cooking demonstrations by HSE ‘Eat Well, Be Well’ tutors.

It initially started in 2004 at 2 sites, one rural and one urban and this has increased to a current number of 7 sites. In addition concurrent funding from other sources to the Organic Centre has allowed for the development of schools garden projects and a number of other cross border (with Northern Ireland), community food initiatives.

The project runs for an 8 month period from March to October. Each plot site has a maximum of 15 participants who are recruited through community groups and organisations. The participants meet weekly for two hours and:

- Learn how to grow organic vegetables and fruit;
- Get to know their food and the seasonality of food;
- Grow what they and their families like to eat;
- Learn how to prepare and cook fresh produce and make interesting and economical meals for their families;
- Learn how to store and preserve;
- Learn about the nutritional benefits of fruit and vegetables;
- Are able to cut costs.

An experienced gardener from The Organic Centre guides and helps the participants to grow the food and a trained tutor is present during the cooking sessions to show exciting new ways to cook what has been grown. Participants share the products and take them home afterwards.

Growing in Confidence is a programme that can be used to achieve a number of key recommendations within the Obesity Taskforce Report including:
3.8 Peer led community development programmes should be fostered and developed to encourage healthy eating and active living.

3.9 Community skills based programmes should be developed which provide skills such as food preparation, household budgeting, and those skills which have the potential to promote physical activity.

3.10 Building on the work undertaken by community groups, community initiatives should be developed to tackle the issues of food poverty and accessibility through local food programmes and co-operatives.

4.1 The health services should advocate and lead a change in emphasis from the primacy of individual responsibility to environments that support healthy food choices and regular physical activity.

4.3 The Department of Agriculture and Food together with the Department of Health should promote the implementation of evidence-based healthy eating interventions.

Support: Initially in 2004 and 2005 the project was funded by the Health Promotion Department of the North Western Health Board (NWHB, now part of the Health Service Executive HSE) via the national Cardio-Vascular Strategy, in conjunction with the Organic Centre, a non-profit making company located in Rossinver, Co. Leitrim. However, since 2006 funding has been from the Obesity Taskforce.

The project is managed by a multidisciplinary steering committee that produced a comprehensive How-to-guide for groups looking to set up similar projects in 2006 and made available to interested groups / organizations.

Trigger: Growing in Confidence is a Community Food Project based in the North West of Ireland. The North West is one of the most deprived areas of Ireland with higher disability and unemployment levels than seen nationally.
elderly people and people with a disability. It is thus wide ranging and inclusive. Participants are drawn from a variety of social backgrounds and this creates a matrix of social interests and combines varying skills and talents.

**Evaluation:** Since 2004, an external evaluator has been commissioned to complete yearly evaluations (Share and Duignan 2005, Share 2006, Burke 2007, Burke 2008 (in press)).

Recent independent evaluation found that 86% of participants reported eating more healthily since taking part in the project and fruit and vegetable consumption was increased. In addition, 83% had begun growing fruit and vegetables in their own garden at home at the time of the evaluation. This demonstrates clearly the efficacy of the project in terms of promoting fruit and vegetable production leading to subsequent increased dietary intake among the population.

The manual labour involved in the project provides an opportunity for physical activity among the participants, both during the project sessions and through encouraging participants to garden at home. This represents an additional benefit of the project in terms of promoting the prevention of obesity and other diseases. 91% of participants reported that they were more active.

The project provides an opportunity for participants to socialise with other people from a diverse range of backgrounds. In addition, learning a new skill also helps to foster feelings of confidence and self-worth. This in conjunction with increased physical activity and healthier eating patterns can contribute to an improved mood and sense of well-being. The evaluation showed that 81% of participants felt less stressed and many feel happier with their lives.

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The Limerick City Community Growing Project is a City-wide Community Garden initiative to develop Community Garden and Growing schemes in disadvantaged areas across the city.

**Aim:** The aims and objectives of the project are:

- To improve access and availability of fruit and vegetables.
- To provide a learning opportunity on basic garden skills and techniques that can be mainstreamed and made accessible for all in the community particularly those facing difficulties in accessing healthy affordable food.
- To ensure the development and maintenance of allotments with ownership and participation by the community enabling recreational and therapeutic activity for residents.
- To promote environmental awareness and provide opportunities for training in recycling organic waste and water re-use.
- To provide a focus for the community. We intend that these community growing initiatives will serve as a setting for community education, and will be inclusive in helping to reduce isolation and to provide meeting places for young and old, and those with disabilities.

**Design:** Limerick City Community Growing Project is a City-wide Community Garden initiative to develop Community Garden and Growing schemes in disadvantaged areas across the city. The project will play a lead role in the creation of community gardens and allotments as part of the Regeneration process in Limerick. There will be a strong educational emphasis where it is intended learning at the community gardens will be transferred to participants own homes. In addition, participants will have the opportunity to participate in the Cook It programme.

‘Cook it!’ is a six week nutrition education programme which aims to provide practical information on healthy eating and improve skills by showing participants ways to provide healthy, nutritious, low cost meals and snacks for their families. It also puts the healthy eating guidelines into practice in an easy, relaxed and fun way. The healthy eating message to eat more fibre, eat less fat, sugar and salt is incorporated into all the dishes prepared and sampled during the course. Those taking part in ‘Cook It!’ learn from each other and get the chance to experiment with dishes that are quick and easy to prepare. At the end of a session food prepared may be eaten and enjoyed by adults and children alike.

**Support:** The Community Gardens are at the early stage of development and are working in tandem with the Regeneration Agency, Communities and supported by the Limerick Food Partnership.

Funding was sought and secured from Health Promotion HSE late in ‘08 and funding for the ground work was received early ‘09.

**Trigger:** A Health Impact Analysis of the Regeneration areas of Limerick identified that these proposed areas of high density urban communities would benefit from community gardens and growing spaces. The project arises from the work of the Limerick Food Partnership and it was decided to seek out communities interested in becoming involved.

Evidence suggests that people living in disadvantaged communities are found to have:

- Less healthy diet experience
- More health inequalities
- Less Physical Activity
- Have less access to fresh fruit and vegetables
**Targeted Communities:**

- Lower Socio-Economic Groups in the Limerick Regeneration Area
- Women’s groups and men’s groups
- Older people in day care groups
- Residents in homeless hostels;
- Mother and toddler groups
- Young/ single parents;
- Teenagers and Youth clubs
- Young people leaving residential care

**Evaluation:** Participants are asked to fill in an evaluation form on completion of the Cook It programme and the evaluation of the growing project will be ongoing, including a pre and post nutritional knowledge questionnaire.

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This intervention is embedded in to an already existing budgeting course for persons having debts. Two out of thirteen obligatory meetings are focussing on nutrition, with the aim to show that healthy and tasty food doesn’t always have to be expensive.

**Aim:** The main goal of this initiative is to learn participants how they can buy healthy food with a limited budget. Besides this, the project aims to increase the variety in meal contents of the participants. It aims to decrease the intake of saturated fat, and to increase the daily consumption of fruit and vegetables.

**Design:** While the title of the project invalidates the presumption that healthy, good nutrition is always expensive, it also emphasises the subject ‘money’. The intervention aims to target communities with a low income or even having debts. By linking the health aspect to costs, the target group is probably much more interested.

The project is part of a course for clients of the Integral Debt Assistance – a budgeting course. Participants are obliged to attend 13 meetings, and one group consists of 6 – 12 persons of either man, woman or couples. Topics that are discussed during the course can either be: how to deal with debts, purchasing and budgeting, supermarket tour, saving money, healthy and inexpensive food, and many more. Two out of 13 meetings are focussing on healthy nutrition, with duration of 2 – 2.5 hours each.

During the first nutritional meeting, a dietician gives information about healthy nutrition in general and gives examples of how to purchase and prepare food in a healthy and cheap way. Participants can also discuss the difficulties they experience when they want to buy healthy food, and how to deal with this. Also, labels of food packages, daily amounts of fruits and vegetables and inexpensive alternatives are discussed. The meeting also contains a taste exercise.

The second meeting about healthy nutrition partly takes place in a supermarket. Participants get a supermarket tour whereby they learn how to read labels and compare different brands according to the price/quality relation. Furthermore they receive tips how to make healthy and inexpensive choices about buying food.

After the course, a leaflet named ‘top ten healthy nutrition’ is distributed among participants even as the brochure ‘Healthy and tasty food for less money’, that explains how you can compose healthy weekly menus with the minimum amount of money (€ 53 for two adults and € 82 for a family with two children. They also receive an information file with background information, two homework assignments (one about the information meeting and the other one about the supermarket tour), taste sessions and a free food package.

At the moment this course is taking place in Maastricht and Sittard-Geleen, two cities in the south of Holland, in the province of Limburg.

**Support:** The theoretical meeting and the supermarket tour are both led by an official dietician.

The budgeting course (including the two meetings of the project ‘Healthy nutrition doesn’t have to cost much’, is financed by the local authority of Maastricht, department of Socio-Economic Affairs.
The costs for participating in the budgeting course are €339,-. This course is organized and coordinated by the Limburg Credit Bank, in cooperation with the Local Authorities. Furthermore, the dietician has to be paid, but the supermarkets cooperate on a voluntary basis. The materials that are used during the course are available on the website of the Regional Public Health Organisation of South Limburg and are free of charge.

**Trigger:** This intervention was developed on request of the Limburg Credit Bank, because they frequently noticed that their clients – who were having debts – were saving on food. A whole week of eating junk food was normal, because it was cheap, easy to prepare and tasty. The aspect ‘health’ is often not an issue for these people, as healthy food is more expensive most of the time.

To show persons that healthy food can also be inexpensive, the Limburg Credit Bank therefore asked the Regional Public Health Organisation of South Limburg to develop a module to inform persons about this possibility.

**Targeted Communities:** The participants of the budgeting course are having an income of 94% of social security level for at least 3 years. Approximately 50% of these participants are having a low socio-economic status (internal data of the Limburg Credit Bank). Because the intervention hitched on to this obligatory course, the target group – who is normally difficult to reach – is rather easily reached. Furthermore with this set up it is therefore not necessary to start separated courses that need separate financing as well.

**Evaluation:** A non-randomised quasi-experimental study (Van Assema et al., 2005) has directly proven that the ‘Healthy nutrition doesn’t have to cost much’ project has an intervention effect on fat consumption (the consumption of saturated fat during the main meal significantly decreased) and fruit juice consumption (the fruit juice consumption significantly increased). Furthermore, almost all of the participants of this study reported to be were more interested in healthy nutrition after following the course. However, no effect was demonstrated on the fruit and vegetable consumption before and after the intervention took place.

Another study by Geerts (2003) showed that persons with a low socio-economic status prefer practical activities to listening or reading. The supermarket tour is a good example of such practical activity, and this design has proven to be effective during other interventions as well (Baic and Thompson 2007). Participants of this last study changed their purchasing behaviour towards a healthier choice and learned how to read the labels. On the long term the supermarket tour had a positive effect on the consumption of saturated fats and fruit and vegetables (Baic, 2008).

A strong element of this intervention is furthermore that the approach is focused on money and not primarily on health, because of the budgeting course. With this point of view, an appealing design is created for persons with a low socio-economic status.

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This is an example of a running SchoolGruiten project in a city in the Netherlands – Amsterdam – that specifically focuses on children from areas of deprivation. The general description of this programme can be found in chapter two.

**Aim:** The programme aims to stimulate healthy nutrition among lower socio-economic children, by letting pupils (class 3, 4, 5) from primary schools in deprived areas of Amsterdam jointly eat fruit and vegetables twice a week.

**Design:** The SchoolGruiten – Amsterdam programme started in 2006, and currently 59 schools are participating. These schools were approached by the Municipality Health Authority (GGD) Amsterdam itself, based on their socio-economic status (SES). Only schools with low SES could participate. The schools were offered the possibility of providing their pupils in class 3 and 4 free fruit and vegetables twice a week during the whole school year for as long as there is financing.

But these free fruit and vegetables for class 3 and 4 are only given to the school, if they will stimulate class 5 to eat fruit or vegetables twice a week during the morning break. This can either be done via Model 1 (delivery by a subcontractor – either the school or the parents pay the costs) or Model 3 (parents or child carers give fruit and vegetables to their children to bring to school).

**Support:** The Local Authority of Amsterdam will finance the costs to provide fruit and vegetables for class 3 and 4 of the participating schools for one full year. Often the support of the GGD Amsterdam is needed to help the school with the communication to the parents and the implementation of health policy and regulations in the school itself. The GGD provides therefore promotion materials and thus stays involved, also for the evaluation of the project.

**Trigger:** The SchoolGruiten project is part of the integral approach to prevent overweight and obesity among children of the age 0-12 years old. The local authority of Amsterdam asked GGD Amsterdam to develop the programme.

**Targeted Communities:** This programme is targeting schools that have pupils with a low socio-economic status and who are at risk of becoming overweight or obese.

Initially the programme is targeting children from class 3 and 4, as the chance of drop out (due to movement to another city or changing schools) is significantly lower at this age. Children are thus more likely to stay at the same school when
they reach this age, and they can thus get familiar with the programme in a continuous way. The possibility of changing their behaviour over a longer period of time will increase. Also, the sooner the children get in contact with the programme, the greater the effect will be and thus the more likely that children will indeed start eating fruit and vegetables for at least twice a week.

**Evaluation:** The participating schools are receiving a yearly questionnaire so that the GGD Amsterdam can verify that the schools are indeed still providing fruits and vegetables to the children in the 5th grade and higher. Also, the GGD will collect general information of the progress of the programme (are there any problems with the delivery for instance, do the children like the fruit and vegetables etc.). Also, data about the schools (number of children, when are the holidays planned etc.) will be collected.

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Bridgend Allotment Community Health Inclusion Project

The Bridgend Allotment Community Health Inclusion Project (BACHIP) is both an education and therapeutic resource, aiming to promote healthy nutrition by creating an organic community allotment.

**Aim:** The project was established with the following aim: ‘To create a productive, organic community allotment with an emphasis on the promotion of health and well-being, with the primary involvement of the local communities of South Edinburgh Craigmillar.’

To establish a full programme of activities and events promoting the links between gardening and health, several objectives were set up. Participants would learn:

- how to grow healthy food locally
- how gardening and gardens can promote a profound sense of well-being
- how gardening can be central to structured prescribed plans for (physical) activity for those requiring rehabilitation how gardening can increase confidence and how it incorporates many transferable and life skills
- how organic gardening can increase biodiversity and environmental sustainability and improve the quality of green spaces
- the value of gardening as a group and family activity: the links between gardening and growing food, healthy eating, cooking and eating together
- how to create a sustainable community resource for the future, through effective monitoring and evaluation of the project with full involvement of all, especially community, stakeholders

**Design:** The project began in June 2006 as a one year pilot project of Edinburgh Council’s Parks unit and NHS Lothian. The Project occupies 4 plots within a new organic allotment site comprising around sixty plots, is a referral scheme for social and therapeutic horticulture. It provides opportunities for people to improve their mental and physical health, through a mixture of physical activity, healthy diet, and social interaction.

The project addresses health and social inequalities by fully involving local volunteers, groups and referrals in specified and appropriate gardening activities. It also emphasising the productive elements of the project (gardening is seen as ‘work’), it contributes to consumption through the planting, growing and consumption of food, all of which enhance the quality of life and it provides increased social opportunities, and the possibility for reciprocal relationships to develop within the community for those who share an interest in gardening, vegetable growing, cooking, or simply being outdoors. At last it encourages all people involved to contribute to the running and development of the project, encouraging participation at community level.

The project has been open to participants for two days per week between 10am and 3.30 pm since April 2006, when the allotment site was completed. It has been run as a drop-in facility, with participants deciding on the hours they attend and the frequency. This can vary from participant to participant and from week to week. The maximum attendance has been two full days. In June 2006 the project became available for groups at the site, including e.g. high school children, a group of Sikh women, participants with mental health problems and young homeless women with children.
**Support:** The project is funded by the Big Lottery’s Fresh Futures Fund – part of the ‘Transforming Your Space’ programme. Furthermore, it links in with established groups and organisation, feeding information and findings up to policy and strategic levels. The groups and organisation involved are NHS Lothian, City of Edinburgh Council, Community Regenerations Partnerships, health practitioners, schools, community organisations concerned with linking food, health, physical activity and well-being, National and local voluntary organisations concerned with social and therapeutic horticulture, and national environmental and organic gardening organizations.

**Targeted Communities:** The location of the project is exactly on the boundary between Craigmillar and South Edinburgh. While these communities are very different: Craigmillar having a distinctive unitary identity, and South Edinburgh being a larger, loosely linked collection of areas: Gilmerton, the Inch, Burdiehouse etc, significant numbers of people experience deprivation and health inequalities in both areas.

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Edinburgh Community Food Initiative (ECFI) is a citywide, community-based charity, supporting local groups to run their own food co-ops, training local volunteers in the community and facilitating networking of community groups with each other. ECFI also buys food on behalf of over 40 community groups and local agencies across Edinburgh, ensuring that they receive healthy, good quality, fresh and affordable food for sale within their communities.

**Aim:** The project aims to enable health improvement in relation to poor diet, particularly for people living in low-income areas, by support local groups to set up new projects, help them to be self sustaining, and to encourage them to become aware of what is grown around them and when its in season. It thus aims to improve the supply of quality food (getting food to people) and secondly to tackle barriers to quality food consumption, such as cooking skills (getting people into food).

**Design:** Edinburgh Community Food Initiative (ECFI) – launched in 1996 - is a citywide, community-based charity and company limited by public guarantee. The project is managed by a Board of Directors, the members of which have an active connection to local community food activities, or have related experience or expertise in this field.

The main focus of the work is on reducing health inequalities relating to diet. Early activities included an examination of the barriers to healthier eating for people living in low-income areas of the city. This showed that there were a number of external factors that inhibited positive dietary change. These were understood to be inter-related, to a varying extent systemic, and largely outwit the control of individuals. These factors can be characterised as:

- **Access:** to adequate and appropriate shopping opportunities
- **Availability:** of a range of desired food items
- **Affordability:** of foods required for a healthier diet
- **Aptitudes:** or the skills, knowledge and confidence required to source and prepare appropriate foods
- **Attitudes:** feelings, habits and ideas we have developed and become accustomed to in relation food issues

In more precise terms, a significant proportion of people in low-income situations feel that supermarkets do not provide a service that meets their needs, either because supermarkets might be difficult to access physically or that their shopping needs are not catered for by them.

It was in order to address these issues that ECFI developed its *Provide & Promote* methodology. This entails acting as a wholesaler and delivery service to allow a wide range of high quality fresh fruit and vegetables being made available at affordable prices to local communities, schools, childcare organisations and other projects.

Community food outlets include local volunteer operated food co-operatives, which are typically located within local community facilities such as neighbourhood or community centres, G.P. surgeries, church halls, etc. ECFI delivers a comprehensive range of fresh produce at cost price on a sale or return basis to most of the groups it supports, as well as administrative and developmental support. Operating from its warehouse in the Leith area of Edinburgh, ECFI bulk buys produce from a range of suppliers. These include the local fruit and vegetable market as well as a variety of local farms and producers.

Every week, three full-time and one part-time staff collate and deliver up to around two hundred orders every week. It has a large and wide ranging customer base that includes: sixteen local community food co-operatives, around thirty smaller scale community food access initiatives such as fruit stalls and 12
Children and Family Centres across the city as well as responding to frequent requests to support local community events and projects.

The community programme’s basic order form is made up of around 80 different items of fresh produce, which is supplemented by a range of seasonal items throughout the year. The local food co-ops are supplied on a sale or return basis. This allows them to experiment with more unusual fruits and vegetables as well as to display an abundant amount of produce, helping to create an attractive display. The range covers everything from everyday items of the apples, bananas, tomatoes and potatoes type stuff, ranging through the Mediterranean vegetables like aubergines, capsicums and courgettes to the positively exotic okra, Karela, mooli and physallis and lots more in between.

It is absolutely vital to recognise that information alone will not effectively enable people, particularly those in low-income circumstances, to make positive changes to their dietary habits. Therefore, within the community programme an ongoing programme providing education and group work opportunities helps community groups and other projects to gain an insight into addressing food issues. The main promotional activity involving the food co-ops is the Seasonal Promotion Programme. Co-ordinated and delivered by ECFI, this takes place four times a year and involves all of the food co-ops.

Each promotional event highlights the benefit of a specific fruit or vegetable and each food co-op user is given a free sample of this along with information, recipes and often a chance to sample the featured fruit or vegetable. This allows people to try something that might be unfamiliar to them or to introduce new ways to use familiar fruits and vegetables. Breaking down barriers in this way helps expand the range of healthy foods that people feel comfortable buying.

Support: The Project was launched using grant funding that had been secured by community activists involved in local food co-ops. Nowadays, a partnership arrangement between the City of Edinburgh Council and Lothian NHS Board provides basic funding for ECFI. A number of other funding partners including Sure Start, the Craigmillar Partnership and Community Regeneration Forums in Leith and Lochend and additional funding from CEC Children and Families Department enable the project to run its range of specialist programmes.

Much of this work is done in partnership with other agencies; one of many examples of this is the presence at the Edinburgh Mela along with the Khush Dil project. ECFI and Khush Dil dipped their collective toe into providing a fruit, smoothie and information stall at the 2004 Mela and subsequently built on this experience at the 2005 event, where the British Heart Foundation was an additional partner.

Trigger: The initial funding proposal was the result of discussions between representatives from four local community food co-ops who had come together to look at commonly held issues and challenges. Each of the food co-ops was operating on a very small budget with restricted access to transport. This limited the quantity, variety and type of food that could be stocked. Providing fresh produce was particularly difficult due to a number of factors: e.g. lack of capital; lack of appropriate storage facilities; unsuitable environment; the inability to afford stock wastage; lack of funding for advertising/promotion. The problems expressed by the food co-ops were of a largely practical nature, primarily related to supply issues. The grant funding though, provided for a project that had the potential to bring a wider and more developmental approach to tackling community food issues across the city.

Targeted Communities: Targeted communities of are low-income families, elderly people and people from ethnic minority groups across Edinburgh.

Evaluation: Evaluations are in progress and get monitored on a quarterly basis.

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The Janny’s Hoose is a developmental health initiative with an initial focus on the needs of families with children of primary school aged living in an area of Inverness (Merkinch) with the highest levels of identified social and health need in Highland.

Aim: Janny’s Hoose Healthy Living Centre is focussing on four different themes; Oral health, Nutrition, Mental Well-being and Parental Support. The targets of these four themes were:

- A 10% improvement in children’s DMFT scores and a 10% improvement in parental registration with a local dentist
- An increase in the consumption of fresh fruit and vegetables in 50% of local families with children at Merkinch Primary School
- An involvement of all children of Merkinch Primary School and 50% of parents in activities aimed at ‘feeling good/positive’
- At least 100 places will be provided at ‘Incredible Years’ or ‘Positive Parenting’ courses and at least 500 opportunities for informal drop-in information and advice sessions.

Design: The Janny’s Hoose Healthy Living Centre was set up in January 2003 in an area of multiple deprivations (the 7th most deprived council ward in Scotland at that time). It was set up by a partnership of the local council and NHS and utilised the empty Janitor’s House at the local primary school - hence the use of the name ‘Janny’s Hoose’.

The Janny’s Hoose uses a person-centred approach to all its work. It predominantly uses the social model of health and looks at each person’s health holistically. Although activities are carried out in the Janny’s Hoose, these are not an end in themselves but a vehicle for improving people’s confidence, self-esteem and general health.

People are thus encouraged to take responsibility for their own health, because tackling obesity can be counterproductive; people know when they are obese, but there are more complex issues around obesity than just overeating. With this project, people’s awareness is raised about healthy eating and it raises their self-esteem so that they are more likely to eat a healthy diet and look after themselves.

From the outset the facility was designed to be used (and has been used) by a number of professionals from agencies to conduct clinics to fulfil the original intention that the Janny’s Hoose would be a multi-purpose community facility. For example, clinics in ante-natal care, child health, and smoking cessation have regularly been held in the Janny’s Hoose.

The main activities of Janny’s Hoose are:

1. Reducing social isolation: going out and about - in the playground, street and door-to-door. People are encouraged to come in to get the support they need, firstly by one-to-one and also as part of small groups. Many people are unable to trust anyone as they have had such negative experiences of life.

2. Encouraging people to take part in small group activities: reducing mental ill-health through giving people a reason to get up in the morning. The specific activity is often irrelevant although participants should have input at the organising stage. Encouraging social networks, improving self-esteem and confidence.

3. Encouraging people to move on through providing supported informal volunteering opportunities in the Hoose and training opportunities. This gives encouragement to re-enter more formal education, return to work, take part in mainstream volunteering activities, or join other community groups.
4. Working with other agencies and groups on health promotion. Includes teachers in the school, school nurse, health visitors, midwives, NCH, MP33, Afterschool club, nurseries, Women’s Aid, family centre, dietician and smoking cessation worker.

Many different nutrition-related activities involving parents have taken place under the aegis of the Janny’s Hoose over the 5 years ranging from a veggie barrow scheme selling vegetables and fruit to cooking classes and taking in group discussions on diet and the provision of healthy foods at community events. The Janny’s Hoose has undoubtedly increased the profile of the campaign to increase the consumption of fruit and vegetables in an area of town where nutrition needs are the greatest in Inverness. It has worked with the Merkinch Primary School staff to enable all the children to sample different fruits and vegetables and breads and that work in itself increases the consumption of wholesome food.

As there is currently no prospect of further funding, the Janny’s Hoose project is expected to finish on 31 March 2009.

**Support:** In 2003 it was funded for 5 years principally by the national lottery fund, with contributions from Highland Council and NHS Highland.

Janny’s Hoose was initially led by two part-time staff (a 30 hour a week co-ordinator and a 15 hour a week administrator). These positions were later to be supplemented by sessional workers, the engagement of volunteers and, for a period, another part-time staff member. When the project has to finish, the three staff members will either be made redundant or redeployed within the council.

**Trigger:** The genesis of the Janny’s Hoose project stemmed from two established partnerships – the local New Community School initiative and the Merkinch Social Inclusion Partnership. In developing the Janny’s Hoose Business Plan and accompanying application to NOF, a similar partnership approach as existed within these two entities was developed involving several different statutory and voluntary organisations.

**Targeted Communities:** All the promotion and publicity has been targeted at the area of most need. As the publicity has been very specific about the target group, this has aided in concentrating on this community.

**Evaluation:** Via its Annual Reports to the NOF/Big Lottery the Janny’s Hoose project regularly demonstrated that it had exceeded its targeted outputs for the year under review. With the small, part-time and sessional staffing complement at its disposal it has tackled the planned range of initiatives and it has delivered on the numbers. The project has also won the trust and confidence of the vast majority of those with whom it has worked closely.

There has been much attention given over the last 5 years to promoting healthy schools so it is impossible to ascribe these changes to the influence of the Janny’s Hoose alone. But what can be said is that the Janny’s Hoose has contributed significantly to a set of changes designed to improve the nutrition of the children.

The school has thus benefited from the Janny’s Hoose support in promoting healthy eating. However there is a justifiable feeling that more could have been accomplished with parents and children via this route if there had been greater involvement of the Janny’s Hoose in the life of the school.

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The Children’s Orchard aims to encourage schools, community groups, local authorities and individuals to set up, maintain and use community orchards, for a range of benefits and purposes. The aim is to encourage local ownership of orchards, but linked with a common ethos and purpose.

**Aim:** The aims of the project are to improve children's and public health through better diet, to create any educational resource, that fires the imagination of young people, to create better local environments and improve community cohesion.

**Design:** The Orchard developed since 2004 with the first planting at the Children’s Garden in Glasgow Botanics. The Children’s Orchard developed as an outreach project from the Children’s Garden working across Glasgow and across other parts of Scotland. It has grown, and now operates as a social enterprise with a Scotland wide remit. There was a pilot phase in 2005 with work on delivery of the orchard concept across Glasgow. The strength of the orchard model is that it is cheap and simple, and fits well with the school year.

**Support:** Finance came from a range of small grants, donations, and contributions from the community organisations the orchard supports. Our observation is that when local communities and schools raise money themselves to plant their orchards – they are much more involved and determined that the orchards succeed.

Part of what we do is to broker partnerships and networks. These are varied – from individuals, to community groups, schools, local authorities, and central government agencies of various sorts.

**Trigger:** It was triggered by John Hancox, a journalist, environmentalist, and social entrepreneur– who saw the scope for bringing fruit trees into the urban landscape, and for picking and using considerable amounts of fruit which would otherwise be wasted. It was also triggered by the many children who loved to get their hands dirty planting and digging and trying out planting growing and eating food plants – all with a big smile.

**Targeted Communities:** The orchard tries to be very open and inclusive, and encourages as many schools, communities and agencies to take community orchards forward as possible.
**Evaluation:** There is on-going evaluation of the project – and perhaps the best measure of the success of both the Children’s Orchard and the Children’s Garden is through the number of similar initiatives it has generated. On the back of the Children’s Garden, Glasgow City Council introduced policies encouraging schools to have allotments, and the Children’s Orchard is currently in discussions (as we speak) with the Scottish Government over an ambitious plan to roll out the Children’s Orchard concept across Scotland. The Commonwealth Orchard plan has now been launched – http://www.commonwealthorchard.com - looking to encourage a wide range of schools and communities across Scotland to get growing.

Evaluation techniques have been used – based on the participatory appraisal model – which works well with children involved in doing the evaluation, and interpreting the results. This gives a way in which participants can reflect and improve.

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4.1 Physical Activity Projects

Austria

This is an activity programme initiated by ‘A Heart For Vienna’. It provides participants with healthy promoting information and tips on daily physical activity, and it uses a sustainability concept to ensure people continue to walk, even when the programme stops after 6-8 weeks.

**Aim:** Physical inactivity and insufficient physical fitness are two risk factors capable on their own of contributing to the development of cardio-vascular diseases. Providing an attractive choice of activities to target the physically inactive can markedly reduce the risk of contracting these diseases.

**Design:** With these essentials in mind we developed our activity programme for a set period of time (6 – 8 weeks), giving participants the option to get started at their own convenience. Health-promoting information and tips on “physical activities as a daily routine” are communicated as part of the Nordic Walking course. To make sure the project is a lasting we also came up with a sustainability concept, training dedicated participants in the district to become co-trainers. Interested women and men meet for Nordic Walking lessons once a week. Following the professional instructions of “Geh!sund”fitness trainers they are able to feel how their body reacts to “more” activity (heart and circulation are boosted). The programme is a soft approach for all those who engaged in little or no physical activity before: they can start “right from their doorstep” and are spurred on by the group experience.

During the pilot phase (spring 2008) eight weekly Nordic Walking gatherings were held in cooperation with the Millennium pharmacy. On average approximately 30 participants – between a maximum of 44 and a minimum of 14 depending on the weather - joined in each time. Most were older than 50, many were socially disadvantaged and were well integrated by the group. The “Walking Euro” charged each time did not pose a hindrance either. By the end of the programme small groups had got together and continued walking regularly. They stuck to the same schedule as before (meeting place, time) and maintained contact with the pharmacy.

In autumn we continued our programme in cooperation with two pharmacies, using a slightly adapted sustainability concept. The number of participants varied between 7 and 28, depending on which pharmacy and date (weather) were picked. We plan to continue and expand our programme in spring 2009.

**Trigger:** Experience to date has shown that low-threshold affordable fitness programmes run over several weeks are well able to motivate people to stay active in the long run – even without professional instructions – provided the motion sequences are fairly easy to learn and come with a group experience. It is also important that participants have something, in our case the pharmacy, to go on for support and motivation during and especially after the guided activity.

**Targeted communities:** The activity programme was devised for older, fairly healthy persons who do not necessarily require regular medical treatment, who lack the energy to engage in regular physical activity, who need a professionally looked-after group to be motivated and who do not have sufficient funds to participate in the different courses otherwise available. Having a base location (i.e. pharmacies) ensures that socially disadvantaged persons in particular are addressed.
To reach our programme’s target group we entered into cooperation with pharmacies in Vienna. Walking sticks are distributed free of charge for the duration of the course by the Vienna Sports Office.

**Evaluation:** In total approximately 400 persons, the majority of them women (88%), participated in the project in spring and autumn 2008. Roughly half attended a Nordic Walking cycle more than twice.

**First results and sustainability:** The project’s success very much depends on pharmacists’ commitment and the motivation of participants. The psycho-social element – motivation in the group, solidarity among participants and with the team of trainers – becomes increasingly evident towards the end of the course. Up to 20 persons meet at participating pharmacies to walk together now that the guided Nordic Walking units have been completed. “Newcomers” are welcome too and are given instructions by the more experienced among participants. With the experience drawn from the pilot run we developed a sustainability concept prior to the autumn round. The idea was to train dedicated participants in the cooperating pharmacies as “co-trainers” so that they can support the “Geh!sund“ fitness trainers during the Walking units and ultimately accompany Nordic Walking groups on their own.

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This project aims to encourage children and their parents to make use of climate friendly use of transportation – bus, walking or cycling. It provides either a basic package of information to whoever is interested, or a more intensive programme whereby direct solutions are sought.

**Aim:** This programme aims to reduce car-traffic on the way to schools and it encourages making use of friendly means of transportation (bus, walking and cycling). It cooperates with other organisation in the field and communities to improve structural condition and to raise awareness for the negative health effects of air pollution and the decreasing amount of space to perform physical activities due to car traffic.

**Design:** This programme was developed base on the EU PROVIDER Project (2001/2002; European network for Mobility Management in Schools) and the EU TRENDSSETTER Project (2002-2005; pilot scheme „Mobility Management“ in 4 primary schools in the city of Graz). An Austrian Pilot Programme ran from 2003 until 2006 in sixteen Austrian high schools. The wide implementation of the „klima:aktiv mobil: mobility management for schools“ Project started in 2006.

A basic package of information and teaching materials is provided to 500 schools or teachers in Austria, and 100 schools benefit from a more intensive programme. This means that over the course of a year, a mobility manager helps children, teachers and parents to find local solutions for their mobility problems. Road safety measures can be taken or innovative approaches such as roundtables with children and community members, including transport company staff can be set up. Also, since 2008 a special workshop and material is offered to teenagers regarding this topic.

All these interventions will eventually result in better mobility options for children to go to school as there is less car traffic around the schools, more awareness of children’s need for physical activity, a clean air and more pleasant journeys to school.

**Support:** The project is financed by the Federal Ministry of Agriculture, Forestry, Environment and Water Management. Many interest groups are involved (e.g. communities, parents, teachers, police force, doctors and the Federal States).
**Trigger:** Motorised mobility is a growing problem for climate protection in Austria and Europe. The transport volume is rising and more and more children are taken to school by car. This leads to an increase in traffic and risk for accidents, and therefore parents are tempted to take their children to school by car in stead of letting them walking on the street. Mobility management wants to break this spiral. With different targets groups (schools, community, parents, teachers, police, doctors, etc) measures are set up to create safe streets for children.

**Targeted Communities:** Children and young adolescents need a special platform to express and present their ideas of how a safe street and a child-friendly environment should look like. This platform is offered by this project. It targets all regions in Austria; schools from both rural and urban settings are participating.

**Evaluation:** The health effect has not directly been analysed. But in between December 2005 and November 2007, around 190,000 daily rides by car to 50 schools have been transformed into a more climate friendly way.

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This is a project in which football players of the Dutch Premier League promote a healthy lifestyle among primary school children (aged 9-12 years) and their parents. Football players are often a role model for children. With the project Scoring for Health professional football players show children that it is fun to be physically active and to feel fit.

**Aim:** By using Dutch Premier League football players as role models, this project aims to convince children that it is fun to be physically active and to feel fit.

**Design:** The first pilot year of Scoring for Health started in October 2006 and lasted until April 2007, since 2007-2008 it has become a regular programme, in which all 18 Dutch Premier League clubs join together. In the season 2006-2007 927 children participated from 25 schools aided by 9 Football clubs, in 2007-2008 1.633 children participated from 49 schools from 18 clubs. In the season 2008-2009 we expect about 6.000 children from about 120 schools will join the programme.

The programme starts with a physical activity clinic and a fitness test for the participating children from the primary schools in The Netherlands. They signed an official Lifestyle contract with one of the players in which they stated that they would keep-up or improve their life-style. At school several healthy lifestyle issues such as exercise and healthy nutrition were promoted.

The programme lasts for 20 weeks. The following themes are considered in the 20-weeks:

- Sporting is cool
- Eating breakfast every day
- Healthy physical activity (with attention to: active transport to school, playing outside instead of sitting behind the computer)
- Healthy nutrition (eating 2 pieces of fruit and sufficient vegetables a day, drinking 1,5 litre fluid – especially water - every day)
- Being member of a sports club

**Figure 30: Edgar Davids, star player of Ajax Amsterdam during a school visit.**

*Source: Association 'More than Football*
After 20 weeks the project is concluded with a second clinic and fitness test and the children receive a diploma by the same football player.

All 18 Premier League clubs have assigned (at least) two (ex-) players or trainers as ambassador Healthy lifestyle to the project. They visit schools, and promote our message to the public. During the project the referees and their linesmen walk on the pitch hand-in-hand with Kids Club members of the home playing team with the logo on there shirt during every Premier League match. All the players of the Premier League have the logo of project (‘Scoren voor Gezondheid’) on their right sleeve during all games.

Halfway the season there is a Scoring for Health weekend. It is organized by The Dutch Premier Division, the Sponsor Bingo Lottery, and the 18 clubs. In the former season this has been filled in as follows:

- There was a full page add about the project in one of the national newspapers (Algemeen Dagblad);
- All the Premier League clubs in the Netherlands paid attention to the project. They projected a video of the starting clinics of the project on the huge screens in the stadia. They paid attention to the project in their programme books in the weekend.
- The players walked onto the pitch in a polo with the logo of the project, until they have presented them selves to the audience;
- There is also a Scoring for Health newspaper, which is full colour, and offers information about the project. It is spread house-by-house (for free) in the surroundings of the stadia and the participating schools; every city had it’s own edition of the paper (Rotterdam had three Premier Division clubs, and thereby has three different editions). The total number of newspapers spread was about 1.000.000 in 2007-2008. The newspaper is spread in an amount of about 1.5 million over the country.

In this manner the project receives a lot of media - and therefore public - attention.

Support: The project is carried out in cooperation with 6 Schools for Higher Education (teachers PE / Sports management), and several Municipality Health Authorities (GGD’s), local and regional/provincial sports federations.

TNO Quality of Life is responsible for the monitoring of effects, and it is coordinated by the Health Institute NIGZ, the Netherlands Institute for Physical Activity and Sports (NISB), and the Association “More than Football”.

Figure 31: Koen van der Laak, captain of FC Groningen during a school lunch. Association ‘More than Football’

Trigger: The project is an initiative of the Ministry of Public Health, Welfare and Sports (VWS) of the Netherlands, de Eredivisie CV (the organization of the
Netherlands Premier League), and the Sponsor Bingo Lottery, the social partner of the Dutch Premier League.

**Targeted Communities:** The project targets children from lower socio-economic status groups, as the programme is offered primarily to schools in the lower SES suburbs.

**Evaluation:** Of the participating children in the 1st year 41%, and the 2nd year even 51% belonged to minority groups. The project Scoring for Health has reported significant positive health effects on physical activity behaviour (increases in compliance to the Health Enhancing Physical Activity guidelines, the duration of time spent in sports participation), and nutrition (there was a decrease of number of children drinking soft drinks every day, and eating more than three snacks a day; there was a significant increase in vegetables, and fruit consumption).


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Big!Move is a health promotion method in a local setting, focusing on healthy behaviour and human power. During the course, participants are encouraged to participate in local activities and to organise activities themselves. People, children, all ages, can participate in dance activities at local community centres or in swimming, walking or cycling groups. There are also special groups for elderly people, which convene in residential homes.

**Aim:** Big!Move aims at helping people to become more conscious of the influence they can have upon their own life. This consciousness, together with the understanding and experience that one gains more with healthy behaviour, leads to a healthier lifestyle. The focus is on the person, health, empowerment, and development instead of on symptoms and diseases.

**Design:** The programme started in 2003. The word ‘big’ in Big!Move is the abbreviation of ‘beweging in gedrag’ (‘behaviour on the move’).

Both the vision of the health care organisation and the Big!Move method are based on the scientific knowledge of the WHO on health promotion: ‘the process of enabling people to increase control over and to improve their health’. Although the WHO knowledge is the most important, other theoretical models are used as well: the Theory of Complexity (Pisek, 2003), the Trans-theoretical model, and a developmental approach, all used in contrast to the rational, managerial approach (Van den Nieuwenhuizen).

The programme Big!Move forms a bridge between health care and individual participation in local activities in the neighbourhood. The main setting is a city area or neighbourhood, because in principle, the programme is directed towards all inhabitants of such an area. Within this area, the programme settings are the health care centre, community centres, residential homes, schools, et cetera.

The general practitioner (or another health care worker) informs, advises, and motivates a patient with lifestyle, behavioural or functional problems to actively counter his or her lifestyle factors. When the patient is sufficiently motivated, the GP then refers him or her to a health promotion organisation. Sometimes, the patient first needs the in-between step of attention being paid to his or her symptom as a way to get activated. The patient gains insight in his/her own part in and responsibility for his/her health.

Next, the intake is carried out, based on the ICF, the International Classification of Functioning. A blueprint is made of the patient’s functioning, divided into objective measures on the one hand and subjective measures on the other, which we state as the most important as it represents the patient’s view. Together with the person doing the intake, the patient sets goals for his/her change. He/she chooses between an individual trajectory or inclusion in a Big!Move group (or another offer), pays the mandatory modest contribution and becomes a participant. The intake is a crucial part of the process as this is often the moment when the patient sees possibilities for increasing his or her health and makes a commitment to participate.

Big!Move consists of three phases and an optional fourth phase. After the intake, people enter phase 1. In this phase, people participate in a group activity, with intensive counselling by two supervisors. In addition to their physical strength, they try to improve the mental and emotional strength of the participants as well. After 12 weeks, an evaluation is carried out based on the intake and another blueprint is made. Participants can now choose to go on to phase 2. The participants are encouraged to get more active in their own environment; they are invited to engage in other activities in the neighbourhood. In phase 3, participants are encouraged to keep on moving and exercising more, independent of but in relation with the organisation. Besides this, the
organisation organises some group activities to let participants reflect upon their own experiences. In the fourth phase, the participants organise a group or an activity themselves; they become social entrepreneurs. More and more people reach this stage.

The programme reaches most people during their visits to the general practitioner or another of the Centre’s health care workers (the physiotherapist, dietician, or a general practice assistant). The Venserpolder health care centre in Amsterdam has 7000 registered patients. Sometimes, participants to the programme have also been stimulated to take part by other professionals, such as social workers or school teachers. The general practitioner refers inhabitants (with health problems like diabetes, overweight, cardiovascular diseases, stress and tiredness) to the programme.

The Foundation Big!Move Institute has been founded for the dissemination of the Big!Move method and the vision on health promotion, and for supporting the transference of local knowledge and experiences. By now, Big!Move is being carried out at six other locations in the Netherlands, four new areas are being currently trained. In addition, it will be started in a number of (disadvantaged) neighbourhoods in Amsterdam as part of the municipal programme ‘Move Better’. Other cities and regions are showing an interest as well in starting with the method.

Support: Until now, the participants, Health Care Insurer Agis, and the district council provided the funds for Big!Move. The participants pay a (small) contribution, 60 Euros in total (10 for the intake, 20 for phase 1, and 30 Euros for phase 2). Thus, people pay for phase 3 themselves. This might consist of swimming, for example, to which e.g. the municipality contributes a small subsidy for the rent of the swimming pool, making this a feasible undertaking. Phase 3 can consist of any regular activity on offer or under development in a neighbourhood. Usually, hiking groups are for free, or they have some small fund. Venserpolder has a hiking and training group, the participants of which pay 10 Euros a month as a stimulus, which enables them to engage a trainer of to go on an outing.

Stakeholders involved in the programme are the health care centre and its workers (general and paramedical professionals). In the area, other health care-, social care-, and social organisations are involved, like residential homes, social work, community centre, or housing corporations. These stakeholders are involved with an eye to the goals of the programme. Furthermore, on the local policy and funding level, stakeholders are a health care insurance organisation (Agis), the municipality, and the district council. These stakeholders are involved in order to achieve a broader dissemination of the programme, as well as its structural embedding and funding.

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Venserpolder health care centre services many patients with symptoms and diseases related to an unhealthy lifestyle, such as obesity, cardiovascular diseases, diabetes, or mental disorders.

**Targeted Communities:** In principle, the programme aims to address all the inhabitants of a city area or neighbourhood, all ages.

**Evaluation:** Three evaluation studies were carried out, all three with a different character.

The evaluation in 2004 consisted of a qualitative description of the Big!Move programme; of the programme’s effects on its participants, professionals, and the organisation; of the organisation itself; of communication and expenses; it also examined the programme’s feasibility and transferability (Overgoor & Aalders, 2004).

**Results:** This study showed that the most important effect is the behavioural change in the participants: of the 100 participants, 84 exercise more than they did before starting with the programme. Eighty-eight percent has become more active in daily life, 69% has independently started to do a sport; 51% has become a member of a community centre or local association.

Hardly any objective indicators could be found during this study to establish a direct, causal relation between the activities of the project, through awareness-raising and behavioural change, and a measurable health gain. For this reason, an evaluation study on the experiences with the project’s ongoing processes and programmes on offer in the Venserpolder was conducted.

An evaluation study in 2006 examined the experiences of those involved with the ongoing processes and programmes on offer in the Venserpolder project (Wieringen & Thomas, 2006).

**Results:** Many (former) participants have kept on exercising, still have more social contacts than before, and/or feel better. For this group of participants, we can consider this to be a very positive result; it is a (generally obese) group of people, who are hard to get to exercise, among other things because of their bad health, lack of social contacts, and low socio-economic status. However, for a number of Big!Move participants, the programme has not been successful in making them aware of their own options for behavioural change.

Almost all respondents were positive about both the organisation and the content of the programme. The participants have enjoyed taking part, are sorry that the programme has ended for them, will keep on exercising, et cetera. The pleasure in the group and the support of the trainers seem to have been the most important motivators for the participants.

The third study evaluated the dissemination of Big!Move to three locations under the authority of Health Care Insurer Agis (Overgoor, et al, 2007).

There is much interest in Big!Move, both from health organisations and policy makers. Big!Move has been chosen in May 2008 by the Innovation platform, an initiative of the ministry of Healthcare, as one of the ten most groundbreaking projects within the Dutch healthcare system. It has also been referred to in a number of policy-making and professional publications as a good example, e.g. in four of eight essays on prevention in the health care insurance for The Health Care Insurance Board (CVZ) (CVZ, 2007). At last, Big!Move has been nominated for several awards. In November 2006, Big!Move won the Cees Korver Award. This is a regional award for innovative projects within health care.

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The project ‘Gezonde Playground’ or Healthy Playground (HP) is intended to develop a programme for the development of healthy outdoor sports- and play grounds that stimulate healthy exercise, eat and drink habits, and healthy behaviour, especially directed at the neighbourhoods with high low-income groups and migrant youth.

**Aim:** To develop an effective way to stimulate healthy behaviour that can have a positive effect on the wellbeing of individual as on the neighbourhood.

**Design:** A pilot phase has started the 1st of December 2008 and will last till April 2009. In this period the Healthy Playground programme is developed based on literature study, meetings with experts, and questionnaires to experts. Two pilot locations have been chosen: the Krajicek Playground at the Hondiusstraat in The Hague (Valkenboskwartier Segbroek), and the public schoolyard at the Amstelmeerschool in Amsterdam (Nieuwendam, Noord). These two locations will be developed according to the findings on Healthy Playground, and will give input for the further development of the programme.

**Support:** Local parties are involved as (primary) schools, kindergartens, the community, etc. On the national level Covenant Overgewicht, NISB (the Netherlands Institute for Sport and Physical Activity) and the Richard Krajicek Foundation (RKF) are involved.

The Convenant Overgewicht instituted by the Ministry of Health, has given the NISB a small budget (€ 17,000) for the first phase. Other costs will be funded by the NISB and RKF. For local implementation of the Healthy Playground in a city, the local government will have to provide funding.
**Trigger:** The project was initiated by the Richard Krajicek Foundation as part of their programme. The RKF has been developing playgrounds since 1998. The focus of the playgrounds is besides the hardware, very much on the ‘software’: the people that provide a socially secure surrounding through guidance as sports instructors, schoolteachers, volunteers, youth from the community, etc. The aim of the foundation is to constantly improve the Krajicek Playgrounds concept. One of the targets is that more and other (girls, inactive children) children can be stimulated to be more active on the playgrounds, especially by learning healthy behaviour and habits.

**Targeted Communities:** The Krajicek Playgrounds are benefiting disadvantaged communities.

**Evaluation:** The programme is still in its pilot phase, so no evaluation has been carried out yet.

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JUMP-in is a systematically developed primary-school-based intervention that focuses on the use of theory, environmental changes, parental influences and cooperation with multilevel parties in intervention development. Six school-based programme components were set up to promote physical activity.

**Aim:** The programme aims to promote physical activity among primary school children in deprived areas in Amsterdam, and to make them more aware of the influence of nutrition on your body.

**Design:** The project, which started in 2002, is a joint project involving municipal authorities, local sport services, primary schools and local sport clubs. It focuses on primary school children in Amsterdam, from 4-12 years old. Special attention is given to the children with a low socio-economic status. The parents belong to the target group as well, since their knowledge of the importance of physical activity and the way how they can support their children to improve their fitness is minimal most of the times. Parents are thus actively involved as well, also since they are the first ones responsible for the health of the children.

According to the Norm of Healthy Physical Activity (Kemper, 2000), children up to 18 years old should be physically active at a moderate level of intensity for at least sixty minutes a day, and at least twice a week. These activities should aim to improve the physical fitness and they should focus on power, flexibility and coordination.

With this norm in mind, six school-based programme components (both activities and instruments) were developed, in order to bring all parties together (the school, pupils, teachers, parents, sport clubs, neighbourhoods and the municipal). Each component is separately organized, but together they form the total programme of the JUMP-in initiative. This is the power of the Project: cooperation between different parties, and a structural implementation of the programme.

The six school-based programme components focus on action points at both personal level and physical and (social) environments (e.g. family members, friends and peers in the classroom), and were designed for permanent use during one school year. These JUMP-in components are:

1. School sports activities
2. A pupil follow-up system
3. The Class Moves!® (in-class exercises)
4. Choose your Card! (lessons aimed at increasing awareness)
5. Parental information services
6. Activity-week

**Description of the components of the JUMP-in programme**

1. **School sports activities**

   Easy accessible school exercise activities are offered in or near to the school premises. During school hours children get acquainted with a variety of sports, each sport a number of times in several weeks. Subsequently they can join the club out of school hours. School sport activities are characterized by continuity. As far as possible, use will be made of the normal local range of physical activities and existing sports activities in the area, and the school child care centres in the school. ‘School sports activities’ is designed to be adopted in the regular school policy, in order that school sport activities will be available all school year long.

2. **Pupil follow-up system**

   The physical education (PE) teacher monitors the pupils once a year, in order to stimulate pupils in a structured way in their development in the areas of sport...
and physical activity and in attaining the physical activity recommendation for youth (i.e. at least 60 min of moderate-intensity physical activity on most, preferably all days of the week, including twice weekly activities that aim at increasing or maintaining physical fitness (Kemper et al., 1999). In cases where support or care is required, use is made of the existing school network channels.

3 The Class Moves! * (De klas beweegt! *)

This programme offers during normal lessons regular breaks for physical activity, relaxation and posture exercises. The aim is to make physical activity a daily habit, to give the children pleasure, awareness and more self-esteem, and to contribute to a healthy sensor-motor development. The Class Moves consists of calendars, each grade had its own calendar. The calendars contain exercises separated on 10 themes, each for every school month. Teachers need to be trained to use ‘the Class Moves!’

4 Choose your Card!

This is a newly developed card game approach that works with assignments to be done in the class and at home. The method is especially aimed at raising awareness on the importance of physical activity for health and one’s own physical activity behaviour, self-efficacy, social support, planning skills, of both the children and their parents. The cards can also be used to prepare an Activity-week and an exhibition. The development of ‘Choose Your Card’ was supported by a group of experts on the terrain of physical activity determinants and the implementation of health promotion in schools, and the Dutch Heart Foundation. The cards are used to prepare for an Activity-week and are linked to an exhibition.

5 Parental information service

A service in which the importance of physical activity and sports for children and the role played by parents in supporting and stimulating such activity among their children is emphasized. The information can be given in the parents’ own language by specially trained information officers. ‘Parental information service’ will take place at least once a year.

6 Activity-week

In the Activity-week some components of JUMP-in are brought together. Parents play an important role in this week. Some examples of activities in this week are: a sport and activity exhibition where products of ‘Choose your Card’ are presented, sports activities and during the week, a warming-up session for parents and children and a sport market where parents and children meet local sport clubs. In this week parental information services will be carried out. ‘The Activity-week’ will take place once a year.

Every school will set up these sports and activities program individually, based on the composition of the pupils and the need of physical activity.

From 2002 until 2004, the pilot of the JUMP-in project was launched in two parts of Amsterdam (Slotervaart and Amsterdam North) at four different primary schools. At those schools, 36% of the children were obese. The pilot study resulted in an improvement of the school-based programme components and the development of materials to support the introduction of the Project at new schools. JUMP-in is nowadays active in seven different parts of Amsterdam, covering 60 schools in total.

A team of the JUMP-in Project goes to the schools on a yearly basis to report and register data of all pupils of sport, fitness, and weight in proportion to length. This data are put in a database and used for follow up of every child separately, to see which specific component needs extra stimulation. When the data is indicating that the child needs professional support and help, the school will contact the school nurse. The two parties will together decide whether or not to refer the child should be send to the Youth Health Service (JGZ). After discussing the possibilities with the parents, a final decision is made. In case the parents
decide to send their kid to the Service, the outcomes of the consults will be sent to the school and the JUMP-in follow-up database. This results in a feedback system.

Posters, folders and other promotion materials are used to inform the parents about the Project. Workshops are organized as well, to show the parents what is expected from their children, what kind of booklets and instructions will be used and given to teach them about the importance of physical activity and the parents will learn about simple assignments they can do together with their children at home.

Within the JUMP-in Project, there are several smaller initiatives that are implemented by external relations. These programmes are offered as a support of JUMP-in. Several examples of such initiatives are:

- **On-site Kids fitness**, by Sport Access; this gives both pupils and teachers the possibility to do fitness in a mobile fitness centre. This centre can be situated at the school for a maximum of two weeks. While doing sports, they will also learn about healthy and unhealthy food, their heartbeat and the meaning of calories and fats.

- **Course Healthy Food**, by the Amsterdam homecare; this is a course for parents of a child between 4 and 8 years old who is likely to become overweight. During a couple of meetings, parents will get information about nutrition and how to support their child with healthy eating and physical activity.

**Support:** There are several possibilities for the reimbursements of the costs that are possibly needed for the sport activities organized by the school. Examples of reimbursements that can be used for sport contributions are:

- Pupil reimbursement; this is an agreement by the Service Work and Income (DWI) that parents can request for, if their child is between 4 and 18 years of age and living in Amsterdam. The maximum amount is € 225 a year per child.

- Fund of sports for Youth; the mission of this fund is to offer to as many children as possible (4-18 years old, living in Amsterdam) the possibility to do sports, if they can’t – because of financial reasons – become a member of a sport club. Maximum amount is € 225 per child, which will be used for the reimbursement of the membership costs, but it might also be used for the sport cloths that have to be bought. The money is directly put on the account of either the school or the sport club.

**Trigger:** The immediate cause of the JUMP-in Project was the rising amounts of signals of a decrease in physical activity, inactivity and youth obesity. In 2002, at least a quarter of all children living in Amsterdam were not doing any sports outside school.

**Targeted Communities:** The inclusion criteria for participation of schools are:

- A trained physical education teacher should be present
- The majority of the pupils should have with low socio-economic status
A location should be present where school sport activities could be organized in the school or in the vicinity.

It should be possible to create extra time to integrate extra-curricular activities.

Personnel should be willing to commit to the Project.

The aim of the Project – to promote physical activity among primary-school children – applies to all children. Thus, also the children that are already sport-minded and are not obese can join the activities. However, there are several conditions:

- When there is a lack of spots, the children that are not doing any sports will have priority to the children that are already physically active on a regular basis.
- The children that are already doing sports can only join an activity when there is not enough interest at the group of non-sporting children.
- Non-sporting children who are not overweight (yet) and don’t have any problems in their motoric development, will get priority upon registration.
- The non-sporting children who are overweight and/or show a problem with their motoric development or their socio-economic status, are a risk group and can get via their schools an adjusted program (for example Club Extra or lessons in Motoric Remedial Teaching).
- Obese children with serious physical handicaps will be send to the health services and will get the proper treatment.

The following figure is an example of the composition of a participating school (figure 36).

**Evaluation:** The effects of the JUMP-in project are currently studied by the Municipal Health Services of Amsterdam, whereby nine intervention schools and ten control schools are involved.
Local Active is a working method in which a Local Action Plan Health Enhancing Physical Activity is developed in a city. Special interest is in promoting more intersectoral co-operation.

**Aim:** The project aims to prevent obesity and overweight by promoting local inhabitants of to be (more) physically active and by informing them about the Dutch guidelines of Health Enhancing Physical Activity (NNGB).

**Design:** An intersectoral working group was built up consisting of: local government, regional public health service, Sport councils and sport club, primary and secondary schools, hospitals, dietician, community health centres, general practitioners, physiotherapists, and companies.

The strength of Local Active is the cooperation between all these parties – working with both regional and local networks. By using this integral approach, joined forces and the inset of different experts, successful local projects can be set up. The local government has an important role in agenda setting and taking the initiative to start with the Local Active project.

The ways of working are divers. This can either consist of:

- Formation of workgroups per target group
- Education of inhabitants through newspapers, radio and internet
- Creation of optimum conditions to exercise and an active lifestyle
- Promotion of existing activities (playgrounds, sport association, etc)
- Create support among organisations and inhabitants
- Organize divers local events
- If necessary: develop activities.

The design of the Local Active project can be split into the following steps:

1. **Exploration:** orientation of the problem (insufficient physical activity), resulting in a project proposal
2. **Organisation:** to design a project structure, to develop, organise and plan the actual approach of the initiative, bring regional and local parties together and eventually develop an action plan.
3. **Implementation:** start with the Local Active project and monitor it.
4. **Evaluation:** evaluate the effect of the project, the organisation and the implementation.
5. **Anchoring:** continue with the project in the city on a regular basis.

**Support:** For the set up and implementation of Local Active, local already excising budgets are used.

**Targeted Communities:** The activities are targeting citizens – especially those with a low socio-economic status - who are having an insufficient physical activity and who are obese. The programme can be used for the following groups:

- Youth;
- Adults/employees;
- 50+/persons with chronic diseases or who are physically impaired.
**Evaluation:** The project has already turned out to be successful in five cities in Holland (Woerden, Purmerend, Urk, Waddinxveen and Maarssen). These cities all differ from each other when looking at citizen number, physical activity policy, budgeting and cooperation between local and regional organisation.

A process evaluation has been carried out by Kraakman E. (Evaluation of Local Active, Vrije Universiteit Amsterdam Gezondheidswetenschappen. Woerden/Amsterdam 2007). This study concludes that the working method works quite well as the participating local organizations are satisfied with it.

Furthermore, an effect evaluation on Local Active is carried out at the moment (2008-2012).

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The 60 Minute Kid has been used by Fife Council to assist them in delivering the physical activity message with children up to about 14 years. Initially the 60 Minute Kid was developed as a logo or emblem appearing on materials used by Active Schools Coordinators (ASCs) with parents, teachers and pupils. He has since been developed into a life-size character, with the aid of a special suit, and the character regularly visits schools, clubs and leisure centres to promote daily physical activity to children.

Aim: The aim of the project is to promote the physical activity health message (60 minutes of moderate daily activity) for primary aged children in Fife.

Design: In 2005 it became apparent that pupils in Fife were not aware of, nor understood the physical activity health message in the same way that they understand the 5 a day healthy eating message. It was decided by the Active Schools Manager and the Physical Activity Coordinator to market physical activity and thus devise a marketing tool.

After working with an illustrator and graphic designer, the “60 minute kid” logo was adopted and was used by the 18 Active School coordinators on letterheads, flyers, promotional activity and as a logo on uniform. The logo was introduced over a 6 month period during which time pupils began to recognise it and ask what it was for and if they could meet it.

With pupils asking about “60 min kid” frequently it was decided to commission a full size mascot that could visit schools and events to promote physical activity.

The project is ongoing, and new illustrations have been developed, including adult illustrations and now the Active Family Mascots.

Support: The project has been jointly funded between Fife Council, Community Services, Education Services and NHS Fife. These departments were also the main bodies involved in developing and using the marketing tool. The “60 minute kid” programme is jointly coordinated by Education Services, Community Services (fife council) and NHS Fife.

Trigger: The project was triggered by work being developed in the 143 primary schools in Fife by the Active School Coordinators whose main role is to develop and coordinate programmes to encourage kids to be “more active, more often”. The coordinators looked for assistance in promoting physical activity and wanted something that was eye catching and fun. When working with the children, Active School coordinators were very aware that children knew other health messages such as healthy eating and wanted to try and develop something similar to help promote physical activity. Thus the “60 minute Kid” was born.
**Targeted Communities:** It is important that pupils in Fife understand the health benefits of being active and know how to achieve these. To this end all pupils are targeted and not just those living in disadvantaged communities. Pupils in Fife now have a better understanding of the physical activity message and the associated health benefits.

**Evaluation:** In 2007 an impact evaluation was commissioned by Scottish Government and Fife council to assess if pupils in Fife knew the physical activity message. The evaluation showed that 68% of pupils in Fife understood the 60 minute a day physical activity message compared to only 42% in control schools out with Fife.

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4.1 Combined Projects

Austria

In Shape without Dieting
Schlank ohne Diät

This is a scientifically tested method initiated by ‘A Heart For Vienna’ with the collaboration of Men Health Centre. In the course of the programme participants are given instructions by trained therapists on how to change their eating and physical activity behaviour. They also receive working materials (book, workbook and calorie manuals) which are used during the courses. A five-month follow-up stage with monthly meetings ensures sustainability of the programme.

Design: In the course of the project “in shape without dieting in Favoriten” a total of 18 “in shape without dieting” courses were held between October 2007 and June 2008, which 15 women and men respectively participated in.

Weekly physical activity programmes are offered alongside the “in shape without dieting” courses: Nordic Walking as well as indoor activities, all of them designed as moderate cardio-vascular training which is easy on the locomotor system, with the option of transferring some of the exercises and motions to everyday life. By popular request from participants the courses were extended beyond the project’s duration and were completed as late as December 2008. Continuation of the programme has been proposed but there are no guarantees to the effect yet.

The courses are further complemented by cooking classes where participants get to know new and healthier recipes for use at home.

Experience has shown how important role models are in developing a number of health problems and life-style factors. To address this issue we included gender sensitisation inputs with each course which we created homogenous gender settings for.

Support: The project is funded through the “A Heart for Vienna” programme. Final drafts were prepared by “A Heart for Vienna” in cooperation with university lecturer Dr. Ingrid Kiefer and the health centre for men in Vienna’s 10th district.
While the health centre for men is responsible for the implementation, public relations, scientific guidance and assessment are still very much done in cooperation with the above organisations. A steering group was set up which meets at regular intervals.

**Targeted communities:** Scientific consultation, course drafts, as well as selection, guidance and training of therapists are effected in cooperation with the working group Nutrition under university lecturer Dr Ingrid Kiefer. Emphasis is placed on adapting nutrition logs and notes to meet the needs of socially weaker members of society who often have limited access to education.

Course fees are 15 Euro per participant. This was considered low enough to keep the courses attractive and affordable for socially weaker persons while at the same time implying a sense of commitment to the course. All “in shape without dieting” courses and physical activity programmes offer child care facilities which is an added bonus for single parents in particular. The venue of the courses is Vienna’s 10th municipal district, chosen deliberately because it is strongly affected by social disadvantages, making it possible to reach this target group at the roots.

**Evaluation:** Continuous assessment of the project is provided by the NPO institute at the Vienna University of Economics. Follow-up units for the last course stage have just been completed, which means that figures are available for the first interim evaluation only.

95% of participants were able to reach their goal and lose weight, a total of 679 kilograms were shed altogether. Each participant lost four kilograms on average, some lost as many as fifteen kilograms.

Measurements also show a reduction in abdominal girth of between 0.5 and fifteen centimetres. In total participants lost 731 centimetres of abdominal girth which is an average 4.3 centimetres per person.

We are especially pleased to report that almost all participants (90%) lost weight due to fat loss. Moderate weight loss also makes sense in the long run because experience has shown that people are better able to keep their weight this way.

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The project “Nach Herzenslust – Favoritner Frauen leben gesund” (At your heart’s content – women in Favoriten are living a healthy life) was implemented between September 2005 and August 2007 as a multidisciplinary and intercultural intervention project for health promotion and the prevention of cardiovascular diseases in adult women with their residence in the 10th district of Vienna.

**Aim:** The principal project objective was to provide information and raise awareness on the subject of “cardiac health” amongst women, multipliers, and the general public.

**Design:** A large-scale sensitising and awareness raising campaign was launched in Vienna’s 10th district (with a starting event in a heavily frequented pedestrian area, promotion days on the subject of “Einkaufen nach Herzenslust” (Shopping at your heart’s content) mainly in Turkish supermarkets, the preparation and distribution of multi-language, culture-specific information folders, low-threshold telephone and email service, media work and public relations).

To promote women’s health, a woman’s jogging group and a Nordic walking group were implemented in the Favoriten district, which have been open and free of charge for all women who have been interested in joining in. Women from the target group could furthermore also take part in the three-month cardiac program “Leben nach Herzenslust” (Living at your heart’s content) (nutrition and sports course, counselling, cooking workshops). Offers close to home, target group friendly dates, low participation costs, as well as child care options could guarantee access to socially disadvantaged women. In order to reach migrants, the events were offered also in Turkish and Serbian/Croatian/Bosnian language.

The central element of the project was a continuous on-going evaluation, documenting the expectations, satisfaction, and target achievements of the participants. Therefore it was possible to show necessary changes, and the program could be directly tailored to the requirements of the participants.

In order to ensure a broad basis for the project, an interdisciplinary and multi-professional strategy group accompanied the project. An essential part of the project also was networking and cooperation with those institutions which are relevant for the subject and the district.

At the end of the project, 60,000 multi-language information folders were prepared and distributed, the homepage was used on a regular basis, and continuous media articles on the project ensured a high publicity. The project also included a total of four shopping event weeks, during which multilingual consultants provided the women with information on healthy shopping in central places and in supermarkets. Multipliers were trained and sensitised within the framework of district doctor’s meetings, project presentations and cooperation. Networking with institutions that are relevant for the district and the subject took place at regular intervals at several levels and in different settings.

**Support:** The project was funded by: Fonds Gesundes Österreich, dieSie – Vienna program for women’s health and Wiener Gebietskrankenkassa. The project was sponsored by the Favoriten municipal administration, BAWAG, Novartis, and Guidant.

**Trigger:** According to the Vienna Health Report 2000, women under the age of 75 years in the 10th, 11th and 12th districts have an increased mortality rate due to the high death rate from cardiovascular diseases. Despite awareness raising and information campaigns, both the knowledge about symptoms and risk factors for cardiovascular diseases as well as the exhaustion of the potential of preventive
actions seem to be unsatisfactory. In addition, traditional strategies for health promotion and prevention do hardly reach socially disadvantaged women with a high risk potential for cardiovascular diseases (women with low levels of education and income, migrants, single mothers, unemployed persons...).

As their major objectives participants listed the achievement of healthier eating habits as well as more exercise and sports. These objectives were reached by the major part of the participants in the long term. Average body weight was reduced by 3.1 kg, satisfaction with own exercise and eating habits as well as the self-esteem and the well-being of participants increased significantly. These effects could be proven even after three to six months. In particular, the importance of being in a group and spending time with other women was emphasised time and again.

In summary; the project’s women-oriented, target group specific and holistic approach has proved successful, and has managed to prove the often-quoted inaccessibility of the target group wrong. The great interest in health promotion subjects and the high motivation on the part of our participants have been significant, in particular regarding migrants. It is possible to adequately promote health issues for the target group of socially disadvantaged women – albeit subject to certain premises. The experiences gained from the “Nach Herzenslust“– Favoritner Frauen leben gesund” project has been translated into recommended actions for working with socially disadvantaged women. This policy should and may serve as a basis for similar projects.

At last, demand for the “Nach Herzenslust“– Favoritner Frauen leben gesund” project has also shown that Vienna has a great need for low-threshold exercise and group offers that are tailored to the target group of socially disadvantaged women. These women are aware and interested in health issues – now it is up to the stakeholders to offer support and to allow for long-term changes in their lifestyles.

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**Targeted Communities:** The project focused on socially disadvantaged women with a high risk potential for cardiovascular diseases.

**Evaluation:** The project was evaluated and showed good results. First of all, the project was able to reach the target group: 10,000 direct contacts with socially disadvantaged women (low household income, predominantly low level of education, 70% without regular employment) with an increased cardiovascular risk (overweight, stress, lack of exercise, unhealthy eating habits) could be made. The jogging and Nordic walking groups enjoyed constantly participation, 253 women could be recruited for the “heart” of the project, the long-term course program “Leben nach Herzenslust” (Living at your heart’s content). The group of participants was exceedingly multicultural; more than half of the course contacts were made with foreign language speaking women (56%).
England

Healthy Weight for London’s Children

City & Hackney have among the highest rates of childhood overweight in London – and so will be one of the first areas to run a new series of training events across London, targeting healthy weight in children.

Aim: The aim is that participants will be able to take the information and skills gained at the session back to their workplace and so promote healthy weight in children in the course of their daily activities.

Design: The training days – to be run in November 2008–2009 - will teach City & Hackney participants how to raise the issue of healthy weight with children and their families. They will include information about obesity, nutrition and physical activity, and advise how to best help children and their parents to access local help and services.

Support: The training, which has been commissioned by the Department of Health in England, will be run by the London Teaching Public Health Network: http://www.ltphn.org.uk in conjunction with City & Hackney PCT and is supported by the National Healthy Living Alliance

Trigger: City & Hackney have among the highest rates of childhood overweight in London.

Targeted Communities: Rather than being exclusively for health professionals, participants will be welcomed from a diversity of backgrounds: from practice nurses and school staff to voluntary sector staff to local sports coaches.

The only things participants will have in common are that they have regular contact with children and their families, and are keen to help maintain and improve children’s health.

We recognise that it is not only health professionals who are able to influence the health of children and families – other workers from public, private and voluntary sectors also have important roles to play.3

Evaluation: The project is not evaluated yet, as it has just started.

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3 As part of the government’s Healthy Weight, Healthy Lives strategy (published January 2008), one of the themes, ‘Building Local Capabilities’ aims to “ensure that all those working at a local level – both health and non-health professionals – are aware of their role in promoting the benefits of a healthy weight”.

This campaign aims to make persons aware that it’s not just food and not just physical activity but both which is required to maintain an energy balance. Posters, leaflets and other campaign materials were used to raise awareness.

**Aim:** The campaign aims to raise awareness of overweight and obesity through promoting a healthy balance in nutrition and physical activity. In order to do so, campaign material was developed to show balance of energy in/energy out, and the importance of balance with food eaten and energy expended was demonstrated.

**Design:** The campaign was launched with a road show on 19th of January 2008 in South Sefton and 26th January 2008 in North Sefton. The road show stopped at strategic points and information was distributed by Food & Health Workers. The road show on 26th also incorporated a food demonstration by a local North West chef, Brian Mellor.

From these dates on, the campaign was advertised on mobile Ad vans, bus stop adshels and taxis as well as distributing posters and leaflets to relevant partner agencies. The adshels were displayed on vans just for 3 days to promote the campaign, on the adshels for 2 months (January and February 2008), and on the taxis for one year from (January 2008 – January 2009). The posters and leaflets were distributed to GP practices, community centres, community pharmacies, workplaces and some secondary schools. The campaign was heavily promoted for the first 4 weeks and then continued through use of posters and leaflets which are still being given out. Prior to launch, there was a focus group testing all the materials.

Five graphics have been developed to demonstrate how much energy needs to be expended after eating an item of food e.g. if eaten a medium sausage roll need to brisk 30 minute walk with a dog.

Linked into the ‘Get the Balance Right’ is the Sefton Pedometer Challenge which was launched w/c 4th February 08. The Sefton wide programme offers a free pedometer and information up to 500 participants. Participants were given an induction and information before given a pedometer.
**Support:** The campaign was funded through Neighbourhood Renewal Funding (NRF) funding. Furthermore, there is a local public health food partnership with Sefton PCT, local authority and community and voluntary organisations.

**Trigger:** The campaign was initiated by Sefton PCT in response to helping to tackle obesity agenda and making people aware of energy balance concept.

**Targeted Communities:** During the campaign, it was made sure that the bus stop adshels and taxis displaying the images were in our low socio-economic areas and also in these areas car ownership rates are low so taxis and buses are used by groups in these areas. The posters were also displayed in locations within these areas.

**Evaluation:** An evaluation was conducted by Sefton Primary Care Trust (PCT). 400 face-to-face interviews were carried out in local shopping centres, and 50 interviews in each of the sampling points apart from the more densely populated towns of Southport and Bootle, where 75 interviews were carried out.

In short; one in three respondents had seen, heard or read information about nutrition and physical activity recently. Furthermore, the TV, local radio and leaflets at supermarkets were the most frequently named places respondents had come across the information.

Half of the respondents stated that the campaign they had seen was promoting healthier options. But just under half stated that they had passed the information they had received on, or discussed it with other people. And one in eight respondents had seen the specific promotional material before the interview.

One in three respondents normally accessed health information from their GP or health centre. Magazines, word of mouth, the internet and TV were other frequently given responses. Two in five of those who had seen the campaign before stated that it had made no difference to their eating and drinking behaviour. However one in five stated that it had made them change their consumption of foods and drinks with high calorie content. One in two stated that it had at least made them think about what the food and drink they consume. Three in five of those who hadn’t seen the campaign before felt it was unlikely that what they had seen would change their eating or drinking behaviour. However one in six felt that what they had seen would change their consumption of food and drink with high calorie.

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This health centre delivers Open College Network accredited courses at level one and level two in disadvantaged communities across Bradford. Subject areas include diet, nutrition and exercise.

Aim: This project aims to reduce health inequalities in the area of Bradford, contribute to a better standard of living by promoting healthier living through increased awareness, and provide beneficial activities which are fun and popular.

Design: Highfield Healthy Lifestyle was established in 2001 as a Healthy Living Centre funded through the New Opportunities Fund (the Big Lottery). The programme initially for 5 years was set up to reduce health inequalities in Holme Wood and Bierley, Bradford, both areas in the top 10% of the Governments Index of Deprivation (2001). From 2008 on the organisation changed the status to a Community Interest Company, Limited by Guarantee.

Seven years of development have enabled the centre to build on levels of expertise and also to build strong links within the communities of South Bradford and beyond. The challenges are to development these links further to residents who cannot access our service e.g. people at work.

There is a core staff team of 6, with sessional workers giving added support. There are also volunteers attached to projects who give support to the core team. The core staff team each have responsibility for specific areas of work, whilst also multi tasking to provide a seamless service across all the projects.

In 2006, Healthy Lifestyle started running accredited courses. Prior to that the offered courses were not accredited and thus there was a development opportunity through this. The accredited courses have now developed up to level two.

The courses are interactive and fun; some are family learning and also involve the young children participating with their parents. The people living in the communities where the work is delivered often have poor educational attainment levels and poor basic skills. Getting these people into education as ‘adults’ can be difficult, because of negative experiences they have had in the past. The courses are overcoming barriers to education, whilst addressing the need to educate people to improve their health and attitude to diet and nutrition. Many learners enjoy the courses so much that they ask to go onto the further courses.

As well as the obvious benefits around education the learners/residents about diet and nutrition, leading to a healthier lifestyle, there is also the added bonus of improving the confidence and self esteem of those taking part. This can have far reaching consequences and for some learners it has involved them returning to employment and further education.

Support: Healthy Lifestyle centre is funded until 2011 to run a range of projects for the Primary Care Trust. Furthermore, Family Learning, Education Bradford funds the project to deliver accredited and non accredited courses in primary schools across the Bradford District. The centre receives funding from the Football Foundation to work with primary school children and their families to reduce obesity and promote sport, and the Older People’s Wellbeing Fund are funding a Wellbeing Café and support group for the visually impaired. At last, the centre also takes on a range of freelance work throughout the year by request.

The partners of Healthy Lifestyle include the P.C.T., Family Learning “Education Bradford, National and Regional Healthy Living Centre Alliances, South Bradford Sports Alliance, Holme Wood Community Council and all community groups working within the South Bradford Area. These partnerships are developed through regular attendance at meetings. The centre contributes to
the partnerships through an involvement in decision making processes and posts on various boards.

**Trigger:** As a Healthy Living Centre which started in 2001 funded through the New Opportunities Fund, the need through consultation with residents and other statutory/non statutory partners was identified to improve the diet of the community where we were working.

**Targeted Communities:** The majority of the work is in the Bierley and Holme Wood areas of Bradford - two areas of high deprivation.

However, through some of the work there was a mixture of socio–economic communities and this has worked very well in breaking down barriers. One example was the running of a level 1 course in a predominately white British area of Bradford and another course in a predominately south Asian community in another area of Bradford. A level 2 course was put on and brought members of both these groups together for the numbers required to run the course. The groups started off working separately, however by the end of the 12 weeks they were working closely together, totally mixed and sharing recipes and confidences.

**Evaluation:** Other than the weekly session plans and end of course short evaluations, there are no further evaluations.

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Community Pharmacy Structured Weight Management Programme

This service is a structured patient centred programme based on delivering brief interventions and using motivational interviewing techniques to bring about behaviour change by setting achievable goals over a 12 month period and following up on maintenance up to 24 months (based on NICE guidelines).

**Aim:** The aim of the project is to reduce obesity levels in people over the age of 18 years who have a BMI greater than 25 but less than 40 - or whose waist circumference puts them at risk of developing long term conditions. It is also intended to increase access to and choices of weight management services, as well as identifying those who may be at risk but who are not registered on GP registers. Overall the service is aimed at improving quality of life and longevity of life.

**Design:** This community pharmacy service is an integrated part of the overall PCT weight management care pathway and another intention is to promote increased partnership working between GPs, community pharmacists and other healthcare professionals for public benefit.

Furthermore, a patient survey indicated that people wanted to be able to access weight management services which were local, provided flexibility, were medically endorsed and free of charge. So the pharmacy service was a good fit.

This programme will initially be delivered by community pharmacists though trained technicians who can assess the “readiness to change” of clients before they are enrolled into the programme. Accredited training underpins the service including knowledge of obesity and behaviour change skills.

Over the 12 month programme clients’ BMI, waist measurement and blood pressure are taken at varying intervals. At different sessions, different aspects of healthy lifestyle improvement are focused upon e.g. diet, nutrition, physical exercise, etc. Referral protocols to GPs are in place as well as signposting clients to other services which may be helpful within their locality e.g. fitness clubs, local walks, cooking classes, etc.

A previous pharmacy pilot service had been successfully evaluated in Coventry PCT but this service also included cholesterol testing and diabetes testing. The GPs consulted in the development of the Central Lancashire PCT service did not want to include these tests so it was agreed that the focus would be on behaviour change as the first tier of service. It was important to get multi-professional agreement. Future tiers of service may include pharmacological support via patient group direction (PGD). This weight management service can also be easily integrated into the forthcoming government vascular screening programme.

A pilot project in 12 community pharmacies began in September 08 and was developed as the result of a partnership approach between Central Lancashire Local Pharmaceutical Committee (LPC) and the PCT. Service development was underpinned by a Leadership Programme and the PCT team consisted of a range of personnel from various professional backgrounds e.g. GP, pharmacists, public health, dietician, commissioning, finance. Two community pharmacists were also involved.

**Support:** PCT funding came from savings made by effective medicines management services. Based on successful evaluation, funding is available to roll out to another 12 pharmacies targeted at areas of health inequality. The service is now written in to the PCT strategic commissioning plan as part of CVD primary prevention and hopefully the service will eventually be rolled out to all pharmacies within the PCT.
**Trigger:** Data estimated that in Central Lancashire PCT there were 85,000 people with a BMI over or equal to 30. That meant that potentially around 53,000 people who are 16 years and over and who have a BMI greater than 30 are not registered as obese on any GP practice register. Life expectancy in males and females in Lancashire is significantly worse than average in England. The trigger for this project came from community pharmacists who were aware of national, regional and local government targets and who recognised that obesity is the second most preventable cause of death, after smoking.

**Targeted Communities:** Community Pharmacy is often considered a more informal venue than GP practices and there is evidence that it can attract people who would not normally visit traditional primary care e.g. men. As pharmacies are situated in all localities (including areas of health inequality) where people live and work – and as they are often open for extended hours, they can also be easier to access for example, by working people who do not want to take time off work.

**Evaluation:** Robust evaluation of the service is planned in conjunction with local Institutes of Higher Education using validated tools including patient surveys. Public health data will be collated for all people assessed for “readiness to change” including those registering on to the programme so a better understanding will be gained of which people are registered on to the service. The intention is also to link with SHA/PCT social marketing campaigns to target specific communities.

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Rushmoor Healthy Living (RHL) set up the Fit 4 Life Project to provide individual support to school children whose weight problems are affecting their self esteem and their ability to learn.

**Aim:** The project aims to improve the participants self esteem and show them how they can change their lifestyle to improve their weight, health and ability to improve their educational results

**Design:** In response to the growing concern surrounding obesity rates, Fit 4 Life works primarily with disadvantaged overweight/obese teenagers who have low self-esteem and poor self-confidence. It supports them to make positive lifestyle changes and encourages them to adopt a healthy lifestyle which they will then take on to adulthood.

The project commenced in April 2008, following a successful pilot from January to July 2007 in one school. Fit 4 Life is delivered in three phases, each taking place over the period of a school term:

**STAGE 1 “Recruitment”**: This phase focuses on recruiting participants on the scheme. As there can only be a limited number of participants, it is vital that we target the young people who will benefit most from the project. This will be a key consideration for personal trainers when reviewing the referrals received and deciding who to accept. The selected participants will have a 1:1 interview with the trainer, the main component being a ‘get to know you’ questionnaire. The final stage of the recruitment phase is a fitness test, whereby statistical data (e.g. height, weight, BMI, etc.) are being measured.

**STAGE 2 “Core”**: This stage incorporates a number of various session based challenges in the gym, fun team based games and activities in the school hall/field, nutritional advice, quizzes and holiday challenges to complete when the school is on holiday. The trainers also organize a breakfast club half-way through the scheme, and just before the end. This involves the children arriving an hour before school begins, participating in a 20 minute gym session, followed by stretches and a healthy breakfast of their choice. A selection of cereals, yoghurts, fruit juices and fresh fruit for smoothies are provided. This allows the children to experiment with new flavours and provides ideas for how they can eat breakfast at home.

**STAGE 3 “Reduced”**: This is the exit strategy. The participants are offered a similar level of support the core phase throughout the contact period. By offering a core and then reduced level of support, the new project aims to help prepare the children for their exit from the project. As per the pilot, each child will also be supported in looking at ways to carry on their new healthy lifestyle themselves – for example by encouraging them to join after or out of school sports clubs. Where necessary the activity fund will be available to help those who are unable to afford equipment or clothing needed for a specific sport.

**Support:** Funding was provided by Pfizer (main source), Big Lottery Community Fund, NE Hants School Sports Partnership and a County Councillor grant. This enabled Rushmoor Healthy Living to commence the project in April 2008, delivering it in three schools.

The partners involved in delivering the project are: the three participating schools (Wavell, Connaught and Samuel Cody), the School Sports Partnership and RHL.

**Trigger:** The concept was thought of by an RHL staff member and then, about a year later, a conversation between RHL and the Schools Partnership triggered a formal project proposal. It is an entirely new concept, but based upon data...
linking health to educational achievement. This can only be brought about by one to one support.

**Targeted Communities:** The project can target any area, but schools within disadvantaged communities contain a higher number of young people with unhealthy lifestyles resulting in obesity. Also, they achieve lower exam pass grades and they suffer higher pupil absence rates.

Rushmoor Healthy Living does work hard to address health inequalities and it targets services to these regions. However, in general RHL addresses health issues in all geographical areas.

**Evaluation:** Fit 4 Life was initially piloted at the Wavell School between January and July 2007. Follow-up evaluation relating to the pilot’s participants took place in February 2008 in order to assess the longer-term impacts of the pilot programme. Further to the success of the pilot it was decided to roll-out the project to three schools commencing January 2008. An interim evaluation report was published containing the initial results from the roll-out as at September 2008.

During the last evaluation various forms of data was collected. Primary assessment looked at whether there were beneficial physical changes for those who participated in the project. Additional assessment evaluated whether factors such as attendance, behaviour and confidence levels had improved over the length of the project. At last, observation notes from teachers and trainers were used to evaluate the project’s success.

In short, the report concludes that:

_Wavell_ has just completed its second full “FIT4LIFE” programme, again proven to be extremely successful. The head of year groups and their personal trainer are currently recruiting for the schools 3rd scheme.

_Connaught_ is currently trying out the scheme at the school for the first time. At present, it is at the “reduced” phase of the programme. It has 13 students, 2 of which unfortunately had to pull out due to health reasons. However, the programme has proven to be extremely successful, producing positive physiological benefits, academic improvement, and an increase in confidence. The school is currently recruiting appropriate candidates for the second “FIT4LIFE” Scheme.

_Samuel Cody_ has recently begun the “core” phase of the project. The school has a smaller number of participants due to the students having learning difficulties. The trainer, along with an under graduate volunteer working with RHL on a work placement, train the group of 8 students twice a week, in a gym environment, and in a hall with sports and game based activities. This helps to develop their skills, such as co-ordination and team work, aiming to make the sessions as fun as possible without losing interest. This method will improve their fitness and gain health benefits at the same time.

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The HEAL project (Healthy Eating Active Lifestyle) is funded for three years through the Reaching Communities strand of the Big Lottery Fund. The project is aimed at residents of South West Burnley and the ward areas covered fall into the top 10% most deprived, on the indices of multiple deprivation.

**Aim:** The project aims to address health inequalities in South West Burnley by supporting residents to make lifestyle changes to improve their own health, by providing a range of “healthy eating, active lifestyle” activities targeted at people who live in health deprived areas or come from disadvantaged groups covering the ward areas of Trinity, Rosegrove with Lowerhouse and Coalclough with Deerplay.

**Design:** The HEAL project is a new concept which was initiated by the Chief Officer of the Enterprise Centre. The project runs from the Enterprise Centre building, which is a diverse community facility, offering many services including a fully equipped UK online IT suite and a large catering kitchen. The HEAL project enhances these existing services and serves to attract more local residents to the centre.

The project was chosen as health inequalities are a serious issue within South West Burnley alongside high levels of social isolation, unemployment and high numbers of incapacity benefit claimants. The HEAL project aims to empower residents to improve their lifestyle so they can enjoy improved health, reduced social isolation and increased feelings of self esteem and confidence. The HEAL project also provides free accredited courses, including qualifications in food safety. The aim being is to up-skill local residents to enhance their employability.

The community benefits greatly from the project as they are being offered a wide variety of physical activity sessions, practical cook and eat sessions and accredited courses, which are all free of charge and which have free crèche provision. The activities are delivered at the Enterprise Centre which is a local and accessible facility and courses have also been delivered off site at venues such as local children’s centres to ensure the whole community has access to the services offered. On an individual basis we have seen increased self confidence and self esteem, reduced levels of social isolation and increased skills and knowledge relating to healthy eating, cooking healthy food from scratch and cooking on a budget. We have also supported many local residents in achieving qualifications, including food safety and nutrition and health awareness. The project offers a number of outings each year to venues that include organic growing projects, farms and other attractions that tie in with the health theme. The outings are free to local residents and free transport is provided. Residents are also supported and encouraged to try different activities on offer at other venues in the local area. The health access worker accompanies groups to other activities and free transport is provided with this service.

**Support:** Big Lottery funding was allocated in November 2007 following successful submission of the funding bid.

The HEAL project is delivered in partnership with a large number of organisations and agencies, these include; Freshfields, Greenspace, Homestart, East Lancashire Primary Care Trust (in particular Howard Street Community Health Centre and the Health Trainer initiative), Age Concern, Burnley Borough Council Healthy Lifestyles Team, Burnley Youth Intervention Programme, Burnley Borough Council Neighbourhood Management, Burnley Food Forum and a number of local residents groups.

**Trigger:** The need for the project was evidenced through the results of questionnaires, which were distributed to the local community. The responses to the questionnaires identified that residents felt the HEAL project would
provide much needed local and accessible services and support that would help them to achieve positive improvements in their health and lifestyle.

**Targeted Communities:** The HEAL project effectively targets the most disadvantaged areas as the Enterprise Centre is located in the heart of these communities. Trust is a huge hurdle when it comes to getting people to ‘step through the door’. As the Centre is a local facility, already well known and used by many residents, the barriers of the “unknown” are already removed and word of mouth between local residents is one of the most effective tools in engaging people with the project.

Whilst the HEAL project is aimed primarily at the disadvantaged and health deprived areas of South West Burnley, geographically the boundaries of the project also cover areas where residents enjoy higher socio-economic status. We do not turn anyone away from the activities offered on the grounds that they do not live in a disadvantaged or deprived location. As poor health issues are not exclusive to deprived communities and healthy living is something which practically the whole nation needs to address it is not considered that the project could serve to “widen the gap” between socio-economic groups.

**Evaluation:** Monitoring and evaluation of the HEAL project is ongoing and a formal evaluation of the project, from conception to completion, will be carried out in the months prior to the end of the project.

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The Healthy Living Clinic is a free drop in clinic in Whitehaven, one of the most deprived wards in Cumbria. It operates on a weekly basis where a qualified practice nurse provides blood pressure, cholesterol, blood sugar monitoring and height/weight assessment for indications of obesity.

**Aim:** The aim is to provide support, information and advice to people on a Drop In basis. To enable individuals to make informed choices about their own health and well being to reduce social exclusion and health inequalities through the provision of a free service which also encourages social integration.

**Design:** The Senhouse Centre ‘A Place for Healthy Living’ opened in 2000, after working in partnership with BNFL, Community Action Network, local GP’s and The West Cumbria Development Fund, finance was secured to renovate a building for the centre. The purpose of the centre was to empower the whole community to improve their health through the provision of a large range of services aimed at helping the local community to make positive choices about health and well being and promote healthy living in the community. This holistic approach to health has been achieved by the use of the centre by a variety of therapists, counsellors and community groups using the facilities that supply a range of treatments and services.

When North Cumbria was designated as one of the first Health Action Zones in the country due to the average death from early heart disease and stroke being a major problem, funding was made available for projects that would have a direct impact on reducing death from these causes and in tackling obesity in the community which is on the increase and a major contributor to early death. The Whitehaven Community Trust set up a working group to create a service at the Senhouse Centre that could provide assistance to the community to achieve the governments health objectives.

The Healthy Living Clinic commenced in September 2001 and is a free drop in clinic that has operated on a weekly basis where a qualified practice nurse provides blood pressure, cholesterol, blood sugar monitoring and height/weight assessment for indications of obesity. Advice is provided on healthy eating and exercise and a wide range of leaflets and information is available. The practice nurse will refer the client to their GP or another agency if the health screening identifies anything that requires further investigation. The Healthy Lifestyle Clinic is based in a central location easy to pop into when doing other business in town. The clinic offers an informal non medical setting where appointments are not necessary and time is available to discuss problems. Clients attend with problems that they think they do not want to ‘bother’ their GP with or are ‘time wasting’ to the GP which frequently lead to action being taken that contributes towards a healthier life style. The clinic has been well used since its inception providing a free service that is much needed in an area of deprivation.

**Support:** The Healthy Lifestyle Clinic commenced in September 2001 through funding from New Opportunities, a further three years funding was granted on the basis of the success of the project from the Northern Rock Foundation.

**Trigger:** The Government’s White Paper on Health illustrated heart disease, obesity and stress related diseases are on the increase in Britian with the Borough of Copeland and indeed North Cumbria being no exception. The Borough of Copeland is in the most deprived local authority list, unemployment is high and the area faces an uncertain economic future. North Cumbria was one of the first designated Health Action Zones in the country and the initiative to set up the ‘Healthy Lifestyle Clinic’ in 2001 was based on these factors. Case studies and statistics show the effectiveness of ‘The Healthy Life Style Clinic’ in early detection of problems such as cholesterol, blood pressure, diabetes and heart problems from the subsequent referrals to GP’s. The literature and advice given at the clinic aims to promote good health and wellbeing among all local people,
often resulting in users linking up to other services within the centre such as smoking cessation, menopause workshops and counselling which meets the aims of the project to empower local people to take responsibility for their own health and wellbeing and to reduce social exclusion and health inequalities through the provision of a free service which also encourages social integration.

**Targeted Communities:** The Healthy Lifestyle Clinic is a free drop in service in Whitehaven, which is in one of the top 10% of the most deprived wards in Cumbria, called Harbour. The clinic is easily accessed by public transport by those in surrounding wards that are high on Indices of Deprivation District Scores list. The clinic provides a service to anyone who attends the clinic however we promote and target the service in the areas of most deprivation through local groups and other organisations working in the areas of deprivation. We ask all service users to provide us with a postcode on the register so that we can analyse the areas that are clients live to ensure that the service is meeting the needs of the deprived communities in the area. The project has achieved the objectives, being based in Whitehaven, in the Harbour ward, with the majority of the clients attending the clinic coming from the Harbour ward or the deprived areas surrounding the clinic.

**Evaluation:** The project has been carefully monitored throughout, on uptake and client profile and continues to be well used with the attendance figures for 2008 surpassing those of previous years in the first 10 months, with 546 clients attending the clinic which is more than in previous years and could well exceed 600 by the end of the year. The project has been funded in 3 year cycles and a comprehensive review is undertaken as the period comes to end on the monitoring data and through undertaking case studies on clients who attended with the outcomes both of which indicate that the project is successful in meeting a community need. The health of the people in Copeland has improved since the project was set up but is still generally worse than the England average with death from early heart disease and stroke being a major problem (Copeland Health Profile-The Association of Public Health Observatories 2008). As there has been a move towards better health in the area and are clinic has been a successful in providing a service that identifies the major causes of early death from heart disease and stroke, the Trust feels that the evidence gathered shows the effectiveness of the service in contributing to the improvement of the health of the community in which it serves.

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The Chai Centre is a new initiative that has proved a massive success with the community. By providing several services, it aims to improve health and quality of life and to reduce health inequalities.

**Aim:** The Centre aims to improve the health and quality of life of individuals and communities in Daneshouse & Stoneyholme, and reduce health inequalities, this area being amongst the most deprived wards in the country.

**Design:** The project is a community-led initiative that started in 2004. It was a new initiative that has proved a massive success with the community. The Chai Centre is a combined Sure Start Children’s Centre and Healthy Living Centre, located in the Daneshouse and Stoneyholme area of Burnley.

Services include:
- Children’s Centre services, including group sessions and family support
- Café Culture (open to the public)
- Gym (membership open to the public)
- Exercise classes
- Sauna and Steam Room
- Little Acorns Day Nursery
- Ante-natal care (by appointment)
- North Health Visiting Team
- Women’s health clinic (by appointment)
- Complementary therapies (by appointment)
- Welfare Rights advice (by appointment)
- Smoking Cessation (by appointment)
- Opportunities for volunteering
- Soups and Salads project (healthy eating and cooking skills, by appointment)

Benefits to the community include:
- A healthy living/well-being centre that offers comprehensive services run by staff based on site or other services hosted by the centre that tackle the wider determinants of health
- Volunteering and employment opportunities
- A neutral venue for all sections of the community

Benefits to individuals include improvements in:
- Employment and job opportunities
- Parenting skills
- Health of children
- Access to services
- Fitness levels
- Healthy eating and cooking skills
- Social networks
- Mental well-being and stress management
- Physical health indicators such as weight management and blood pressure

**Support:** The Daneshouse Economic Development Trust - DCEDT (a community organisation) came up with the idea and approached East Lancashire NHS (then Burnley, Pendle and Rossendale Primary Care Trust) who agreed to work in partnership and became the accountable body. Other agencies involved included; New Opportunities Fund (Big Lottery Fund); Bradford & Northern Housing; Daneshouse & Stoneyholme Sure Start & Burnley Borough Council.

The financial support initially came from Burnley Borough Council and Bradford & Northern Housing then proceeded with funding from the Big Lottery Fund – Healthy Living Centre Initiatives and East Lancashire NHS. The project has now
come to the end of its Big Lottery Funding and has recently been mainstreamed by East Lancashire NHS.

**Trigger:** As above, the idea for the centre was community led and thought up by the community organisation (DCEDT) who identified the opportunity while considering the needs of the local community that were not being met.

The community consultation supported the identified need and was linked to the evidence base through various statistics such as census and public health data which clearly portrayed the poor health of the residents in the ward.

The project was chosen because it was innovative and able to target those communities most in need by delivering healthy living and well-being services on resident’s door steps.

**Targeted Communities:** Anyone interested in using the centre or accessing our services is welcome; however, we specifically target residents living in our ward.

**Evaluation:** An end of funding Big Lottery evaluation was performed, describing the success of the Chai Centre. In the future, the café will continue to offer the services and the gym and physical activity facilities are expanding to allow more people to access the facilities and a wider variety of activities to be provided including weekend activities to target more family units to access the centre together.

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This project was an initiative of the London Irish Centre to increase the health of the older and disadvantaged Irish Communities living in London.

**Aim:** The Irish Healthy Living project was set up to increase the health and health awareness of the older and disadvantaged Irish Community in London.

**Design:** The project was initiated by the London Irish Centre in 2003. It is based in the London Irish Centre, which is the largest Irish Centre in London and has been in existence for 54 years. This location was chosen since the London Irish Centre has a good reputation among the Irish community.

The Initiative provides a range of services that aim to improve from physical and mental health, through engaging clients in activities which they enjoy, e.g. allotment project and providing a safe and supportive environment e.g. literacy and numeracy project. Other activities include: advice, volunteering, missing persons, survivors service, day centre activities and lunch club.

**Support:** The Centre received a five years funding from the BIG Lottery fund (i.e. the National Lottery). Furthermore, Camden Primary Care Crust is providing interim funding.

Partners of the Irish Healthy Living Project are the Irish Centre Housing (ICH), Kasiros, ICAP, High & Dry social club, and Job Powerhouse.

**Trigger:** Several reports found that the Irish in England have a shorter life expectancy in the host country and access medical services to a lesser degree than the host population. As a general rule migrants live longer in the new host country – this is not so in the case of the Irish.

**Targeted Communities:** The project mainly targets the older and disadvantaged Irish community in London.

**Evaluation:** The Project instructed an independent consultant to carry out a mid term evaluation covering the period November 2003 to December 2006. The evaluation concluded “the project is implementing activities directly with its target beneficiaries, providing health living information to individuals and groups and encouraging other service providers to address the health needs of the Irish community”. Further, the BG lottery fund has approved the final monitoring form.

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**Aim:** The School dietician project contributes to the general objective of the ‘Urban Action programme Nutrition and Physical Activity in Rotterdam’, which is: to promote healthy nutrition and physical activity among the youth in Rotterdam to reduce overweight and physical inactivity.

**Design:** In 2003, the service Sport and Recreation (SenR), the service Youth Education and Society (JOS) and the Municipality Health Authority (GGD Rotterdam-Rijnmond from 2007 on), started a cooperation to prevent overweight and physical inactivity among the Rotterdam youth.

Since September 2004, the Preventive Youth Health Care (JGZ) uses a national signalling protocol during preventive health examinations to identify overweight youth. In 2007, the JGZ started with the implementation of the national ‘bridging strategy overweight’ (minimum intervention strategy for the prevention of overweight) in Rotterdam. To offer as many overweight children as possible an intervention, dieticians started working on selected schools during the school year 2007/2008 parallel to this program.

The School dietician project is an intervention that is part of the ‘Lekker Fit! Programme’, a school based intervention developed to reduce overweight and inactivity in children at primary schools (grade 1 - 8). The schools that run this programme are selected based on a high prevalence of overweight and the willingness of the schools to implement the programme. The Lekker Fit! Programme consists of an educational package, parental information hours and the introduction of a professional physical education teacher who provides physical activity hours during and after school.

Also, children from grade 3 through 8 have a fitness test at the beginning and end of every school year – a screening for overweight/obesity (BMI) is included in this test as well. The individual results are communicated to parents and children. Children, whose BMI can be improved, are offered the possibility of visiting a school dietician.

The School dietician intervention includes the actual signalling of overweight and the guidance of the parents and the child towards healthier nutrition and increased physical activity. The intake consult takes 45 minutes, and the costs are reimbursed by the School dietician intervention. If a second consult is requested, the parent and the child need to visit a general practitioner first. After this, following consults can take place at the school (max 4 hours per child per year), and the costs are paid by the health insurance of the child. The consults focus on four themes: breakfast, soft drinks, watching TV/use of the computer and playing outside, according to the national minimum intervention strategy.

**Support:** The programme is supported by the Urban Action programme Nutrition and Physical Activity in Rotterdam. The dieticians work closely together with Municipal health service Rotterdam-Rijnmond and the Service Sport and Recreation.

**Trigger:** Overweight and obesity are major public health issues. Overweight is an increasing problem, also among children. In Rotterdam, almost one out of five children in the second grade of the primary school is overweight; 6.4% is severely overweight – obese.

**Targeted Communities:** The School dietician project is running on Lekker Fit! schools in Rotterdam. These schools have – in general – a high prevalence of overweight and most of the parents are from foreign descent.
**Evaluation:** During autumn 2007, a process evaluation of the School dietician project started. The targeted study population consists of the participating children and parents, the dieticians working at the Lekker Fit! schools, and the school management of these schools.

It is important to test the relevance (process) and the effectiveness of the School dietician project, as this is the first time in the Netherlands that the concept of dieticians is used for the prevention of overweight and obesity at school. Several research questions will be addressed:

- The screening and signalling of overweight (number and percentage of children)
- The mode of operation by the dietician (content of the consults)
- The continuation and drop-out of participating children during the consults
- The duration of the consults
- Understanding the attitude towards the project by the participating parents, dieticians and school managements.

Concerning the effectiveness of the project, the BMI and waist circumference of the participating children are studied. During the consults the children are measured and weighted by the dietician and these data are registered. The evaluation includes both a quantitative as well as a qualitative research part. During the quantitative study, data are collected using questionnaires, registrations of information from the dieticians about nutritional or physical activity habits of the child, the screening and signalling of the child who is overweight, the content of the consults and the parents’ valuation of the consults with the dietician. The qualitative study uses semi-structured interviews that will be held with the participating dieticians and the management of the schools. The value, contentment and attainability of the project will be discussed.

The results of this process evaluation study are expected during spring 2009.

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This is a lifestyle programme aiming to reduce the weight of the participants of the course. The participants mainly consist of women from Turkish or Moroccan descent, living in Utrecht.

**Aim:** Weight reduction is the ultimate goal of this programme. In order to realise this, it is important that participants:

1. Gain insight into the relation between overweight, nutrition and physical activity and the role of social pressure, emotions and cultural habits,
2. Gain knowledge about, and abilities in healthier nutrition and an increased physical activity
3. Start to increase their physical activity and start to eat healthier during and after the course.

**Design:** The course, set up for a maximum of 12 women, consists of a physical activity programme and an information programme about nutrition. During thirteen weeks, the women will get twice a week physical activity training guided by a physiotherapist. They will train their condition in several ways. Furthermore, the women will have an information meeting during fourteen weeks. Eight meetings will focus on healthy nutrition, given by a dietician and will be led by a migrant chairman, and four meetings will focus on motivation and reflection and will be given by a migrant chairman alone. At last, two meetings will discuss psychological aspects of overweight, given by a prevention staff member of the GGZ and a migrant chairman.

During the period between spring 2007 and July 2008, seven courses were given in three neighbourhoods in Utrecht. It was given three times to Turkish women, and four times to women from a Moroccan descent. Around 80 women participated in this healthy lifestyle programme in total.

**Support:** This programme is financed by several organisations: Agis health insurances, the Local Authority of Utrecht, Aveant (allowance ZONMw), Portes (community wealth organisation), and GGZ Utrecht.

**Trigger:** Overweight is an increasing problem, also among migrant women. More than 60% of all Turkish and Moroccan women living in Utrecht are overweight, and until the start of this project there was no effective method for the prevention available. However, the need was there. Portes received requests from Turkish and Moroccan women, and the GG&GD had monitored the problem.
and noticed as well that a considerable part of the migrant women living in Utrecht wanted help and information with regard to losing weight. Also general practitioners and physiotherapists noticed the need for a separate information programme for these women, and the regular guidance of a dietician or general practitioner was often even deficient.

At that time there was a community study held in Amsterdam among migrant women and they reported the need for a special programme as well. On a national level there was not yet a successful intervention developed.

Therefore, the GG&GD Utrecht developed in 2006 this lifestyle programme in the format of a course that focuses on healthy lifestyle habits. The course was developed in cooperation with Aveant (dieticians), Indigo (GGZ), physiotherapy practices and the community wealth organisation (Portes).

**Targeted Communities:** The health of migrant women is relatively worse than the average citizen of Utrecht. Often this group is hard to target for the prevention message of a healthy lifestyle. However, by offering this course close to their own environment, the target group was reached.

The programme does not specifically focus on communities with a lower socio-economic status. Nevertheless this group was mainly targeted.

**Evaluation:** To evaluate the effects of the programme, the BMI, the waist contour and the lifestyle habits that were of relevance were measured before and after the course.

At the start of the programme, almost every participant was overweight – 46% was obese and 32% morbid obese. After following the programme, these numbers went down to 41% and 26% respectively. The weight of the participants had decreased on average by 2.2 kilo’s after three months and the waist contour was 4 cm less. The women had also less physical complaints and their knowledge concerning healthy nutrition, eating habits and physical activity increased. At last, the usage of saturated fat, sugar, and the amount of daily meals decreased and the participants drank more water instead of soft drinks.

These results will be officially published in the beginning of 2009. It can be concluded that the programme had an influence on certain relevant lifestyle habits of the participants in regard of overweight. It has proven to be a programme that is interesting to further develop and implement. Currently the reimbursement of the course is being discussed with the health insurance.

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As from 2001 on, a community-based project called ‘Equal Health, Equal Chances’ started in Tilburg – a city in the South of the Netherlands.

**Aim:** The following strategic (intermediate) goals were formulated:

- to support cooperation and synchronisation between wealth- and health organisations
- to expand the basis and participation of communities

The model of Lalonde was used as a theoretical framework.

**Design:** The project – *Gelijke Gezondheid Gelijke Kansen* - was set up in 2001 with a 10-year programme aiming to decrease avoidable health differences and to counteract health inequalities. By providing information, raising awareness and changing behaviour, it influences health related aspects within communities in a positive way.

Most of its activities are ‘to do’-activities, since these motivate lower socio-economic communities the most. Examples are a walking club, cooking classes and a cooking cafe. During lunch meetings for elderly people, information provision is successfully combined with social gathering.

**Support:** Equal Health Equal Chances is a cooperation between: GGZ Midden Brabant (mental health institution), Thebe (home care), NIGZ (Netherlands Institute for Health Promotion and Disease Prevention), local authority of Tilburg and the foundation de Twern (social-cultural work). At a later stage, Novadic-Kentron (addiction care) joined as well. All the organisations put manpower into the programme and it is led by a project leader from the Municipality Health Authority ‘Hart voor Brabant’. The local authority of Tilburg provides a budget for the inset of community health personnel.

**Trigger:** At the end of 1999, Thebe, GGD Midden-Brabant (Municipality Health Service), NIGZ and GGZ Midden-Brabant decided to jointly work on the diminishment of socio-economic health differences. Apart from these four parties, the local authority of Tilburg and the foundation de Twern were prepared to structurally contribute to this project as well. To gain insight in the different goals and grounds of the groups involved, discussions were held with all parties.

**Targeted Communities:** The programme was set up for the lower socio-economic communities living in the neighbourhood of ‘Koninghaven’ in the city of Tilburg. This neighbourhood consists of several sub neighbourhoods: Broekhoven, Fatima, Hoogvenne and Jeruzalem. This neighbourhood is targetted since there are living many disadvantaged communities and there were – at the time the project started – no ongoing health projects and initiatives.

**Evaluation:** The NIGZ has evaluated the project in 2007 while studying the results of the period between 2004 and 2006. In this period, the project succeeded in setting up several structural activities in the neighbourhood. As often is the case – the start of the project (until 2003) was a bit chaotic, but from 2004 a clear choice was made for one theme: obesity, and one determinent: lifestyle. Circa 70 percent of the activities are now designed to promote healthy nutrition and/or physical activity. Three quarters of the interventions are lifestyle based.

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This project was set up by GG&GD Utrecht to improve the health of youth (in relation to obesity and overweight) living in four different neighbourhoods in Utrecht.

**Aim:** The targets of the project are:

- to reduce the level of overweight youth in four different neighbourhoods in Utrecht to the level reached in 2005;
- to stabilize the percentage of overweight youth at this level and if possible reduce it even more;
- to bring study results into practice and to form a basis for further development of public health policies and interventions of the municipality of Utrecht; and
- to create a balanced, fully covering and closing approach for early signalling of overweight children and children who tempt to become overweight.

**Design:** Epidemiological studies show that overweight among youth in Utrecht is a significant problem. Since the city of Utrecht was lacking a programme for the early detection of overweight and an approach to counteract overweight among risk groups (children who are already – slightly – overweight), Agis Health insurances and the GG&GD Utrecht (Municipality Health Authority Utrecht) set up this project. They jointly agreed to reduce overweight among youth in four different areas in Utrecht, and signed a convention for four years on the 5th of July 2006: the Convention Overweight among Youth.

The programme exists of the following components:

- the detection and signalling of overweight and obese youth according to the Nationally developed signalling protocol - This part is done by Aveant (home care organisation) and the GG&GD Utrecht (Municipality Health Authority);
- offering guidance to children (and their parents) who are overweight according to the Nationally developed signalling protocol - Aveant and the GG&GD Utrecht are also responsible for this second component;
- setting up a community approach whereby primary and secondary prevention is aimed at collectives;
- development of a protocol to be able to refer a child to other health authorities;
- implementation of an evaluation study.

**Support:** 70% of the costs are covered by AGIS health insurance, and the remaining 30% are financed by the GG&GD of Utrecht. Besides these two organisations the Aveant home care organisation is involved as well. Within the GG&GD Utrecht, the departments of Youth Health Care and Health Education & Epidemiology are working on this project.

**Trigger:** The project is a new initiative in Utrecht, but the concept is based on a National plan developed by Kenniscentrum Overgewicht.

**Targeted Communities:** Children in these four specific neighbourhoods in Utrecht are targeted, since the percentage of overweight and obese children is significantly higher compared to other areas. Furthermore, the intervention only aims at overweight children from schools in deprived neighbourhoods.

**Evaluation:** The first reports are expected to be published in 2009.

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The InnvaDiab intervention study was set up in 2006 to improve dietary habits and physical activity in Norwegian-Pakistani women living in Norway, in order to reduce the risk of type 2 diabetes and metabolic syndrome.

**Aim:** The aim of the study is to influence risk factors related to lifestyle, such as dietary habits and physical activity in order to reduce the risk of type 2 diabetes and metabolic syndrome in Norwegian-Pakistani women.

**Design:** The InnvaDiab study is an intervention conducted in Oslo. Data collection started in 2006 and ended in May 2008. Two hundred women of Pakistani descent were included and randomised into a control group (100 women) and an intervention group (100 women). The intervention group was offered group sessions and individual counselling that focused on diet and lifestyle changes with regard to diabetes prevention. In addition, the women attended organized walking groups. The dietary advice given to the intervention group was adapted to the Pakistani culture, to study its effects on the women’s knowledge, intentions and dietary habits recommended for this group. There was a pilot phase before the actual project was launched where the intervention methods and the questionnaires were tried out. The financial support came from The Norwegian Research Council, the Health and Rehabilitation in Norway, and the University of Oslo.

**Support:** The project was initiated by researchers in Norway, Margareta Wandel and Gerd Holmboe-Ottesen at University of Oslo and Kåre Birkeland at Aker University Hospital in Oslo. Two doctoral students are employed for working on the project: Benedikte Bjørge who is in charge of the dietary part of the project, and Victoria Telle Hjelset who is in charge of the physical activity part.

**Trigger:** The reason for starting this project is that people from Pakistan constitute the largest ethnic minority group in Norway. South Asians are at higher risk of developing the metabolic syndrome and diabetes type 2 than other population groups. It has been reported that the prevalence of diabetes type 2 in South Asians in Norway is high compared to the rest of the population. In addition, Pakistani women in Norway generally have a higher body mass index (BMI), waist circumference and incidence of diabetes than their men. Furthermore, they are less integrated compared to children and men, and thus, much more difficult to reach. Earlier studies indicate that lifestyle interventions may increase the knowledge of nutrition and health among different ethnic groups and decrease the risk of diabetes and other chronic diseases.

**Targeted Communities:** Woman of Pakistani descent living in Norway.

**Evaluation:** Evaluation of the intervention is presently being carried out with regard to: dietary patterns and dietary intakes, knowledge and attitudes to nutrition and health, fasting plasma glucose, serum insulin, oral glucose tolerance test (OGTT), HbA1c, triglycerides, total cholesterol, HDL-cholesterol, LDL cholesterol, weight, felt barriers for attendance to the group sessions and felt barriers for changing diet. Publications from the evaluation are planned.

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This programme for the adoption of a healthy lifestyle developed by the Public Health Centre of Sibiu was conceived as an interdisciplinary and complex programme for the promotion of a healthy lifestyle and for the prevention of certain affections with a major impact on the health condition.

**Aim:** The aim of the programme is to promote a healthy lifestyle, by changing the food customs and fighting against the sedentary life by improving the physical activity.

**Design:** The programme has been developed since 1997 and it continued as an on-going programme. At the beginning, the programme included a pilot project.

The programme is structured on the following basic activities: education training courses for a healthy lifestyle, individual nutritional counselling, monitoring the somatometric parameters and kinetoprophylaxis. The people who participate in this project receive education training materials, leaflets, booklets etc. containing information on obesity, cholesterol, healthy food, physical activity etc.

The general framework of the programme has been the same since the beginning, but there is a series of new elements introduced, in order to comply with the European actions in the field of healthy nutrition and physical activity.

**Support:** The Public Health Centre was the only partner in the development of this project but it collaborated with different family physicians, school physicians and specialist physicians. All the financial support came from the state budget, as the Public Health Centre is a budgetary institution.

**Trigger:** The project was initiated by the Public Health Centre of Sibiu, a medical research institution under the direct coordination of the Romanian Ministry of Public Health. The launch of the programme was seen as one of the missions of the Public Health Centre of Sibiu, which is to identity and promote better health conditions for the local community. The programme was seen as a public health action and the Public Health Centre was the only institution which participated in setting up the project and its implementation, with the consent of the Romanian Ministry of Public Health.

**Targeted Communities:** The project is addressed to the most disadvantaged communities, especially to the people with a low socio-economic status. The most important benefits of this project are that it is free of charge and that people may come directly, of their own initiative, hearing from others who have participated in this programme. The health status of the targeted people is assessed either by their family or school physician or by the specialist physicians.
who send them to the Public Health Centre, or by the physicians of the Public Health Centre, for the people coming of their own initiative.

The programme for the adoption of a healthy lifestyle is not a restrictive programme. It targets indeed the most disadvantaged groups, but it does not exclude anyone. However, from previous experience, it was noticed that the addressability of the group of people with a higher socio-economic status is quite reduced. Therefore, this project is mainly addressed to those with a low socio-economic status.

**Evaluation:** The project has already been evaluated and it proved effective, although cases evolution and in dynamics certify that certain component parts of an unhealthy lifestyle can hardly be changed (nutritional customs, smoking) and may reoccur after individual attempts of changing them in a positive way. The reduction and the stabilization of the body weight, by combining the measures for changing the lifestyle, proved to be a realistic objective.

The best results were registered among the persons with a continuous participation in the activities included in the programme (healthy food training courses, kinetoprophylaxis, individual counselling).

As a result, we may say that the trend of the mortality due to cardio-vascular diseases, tumours is decreasing in the county of Sibiu.

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Dundee Healthy Living Initiative is a community led health organisation working within disadvantaged areas to reduce health inequalities issues and improve health using a community development approach. Local people and volunteers are an integral part of the project, from helping direct the work of the project to running activities within their own communities.

**Aim:** The key aims of the project are to:
- Develop local activities to improve health
- Help bring health services into the community
- Provide local access to health advice, information and screenings
- Involve local people in decisions about health

**Design:** The Dundee Healthy Living Initiative has a pedigree of over 15 years, growing from a small community development and health project to become a large organisation with almost 20 staff. Essentially, the approach was tested on a small scale for a number of years and proved to be an effective way of engaging with people in disadvantaged areas to tackle local health needs and issues.

**Support:** It is a partnership project with support from NHS Tayside and Dundee City Council, and has a multidisciplinary team of community workers and nurses.

Initially, the Dundee Healthy Living Initiative was established after a successful bid to the Big Lottery Fund, which brought almost £1 million of new money to the city.

Nowadays the project is supported financially from a number of sources including the Fairer Scotland Fund, Keep Well, NHS Tayside, Dundee Community Health Partnership, Dundee City Council, and smoking cessation funding. The Management Group is made up of officers from Dundee City Council, NHS Tayside, Dundee Community Health Partnership, the Voluntary Sector and local people.

**Trigger:** Dundee Healthy Living Initiative came about as a result of an application to the Big Lottery Fund in 2002. The Healthy Living Centre funding programme looked to fund initiatives that reduced health inequalities and supported the health improvement of those people experiencing deprivation and disadvantage. Community health needs investigations had been carried out in Dundee in 1998/9 which enabled 1,400 residents of disadvantaged communities to identify their own health needs and solutions. Results showed that social isolation, poor mental wellbeing, access to affordable exercise opportunities, healthy eating on a budget, adverse life circumstances, and the need for smoking cessation support were key factors for local people in poorer communities trying to adopt healthier lifestyles. These issues formed the basis of the successful bid to the Big Lottery fund.

**Targeted Communities:** The Dundee Healthy Living Initiative built on the success of the smaller project and extended its reach to additional disadvantage areas. The areas the project covers house 54,000 residents – almost half Dundee’s population.

The benefits gained by local people living in project areas include opportunities to increase social contact, learning new skills and gaining confidence, influencing decision making processes, participating in a wide range of healthy activities, and improved mental and physical health and wellbeing. The initiative ensures that
the health gap is not widened by offering activities only in disadvantaged areas in the city.

**Evaluation:** The Dundee Healthy Living Initiative underwent an external evaluation in its first 3 years of funding. From 2003-6 a Doctor of Social Anthropology was sited within the project to assess the impact of using a community development approach to tackling health inequalities issues and improving health. Findings demonstrated that this trust-generating, egalitarian approach encouraged local people to become involved and was successful in promoting confidence and self efficacy to address factors affecting health and wellbeing.

Current evaluation is ongoing within the programme for specific activities and pieces of work relevant to funding accountabilities, reflective practice and quality assurance. The project was awarded the Dundee Partnership prize for Health and Care in 2005, a COSLA Bronze Award in 2004, and the Institute of Sports, Parks and Leisure award for innovation in physical activity in 2008. It was also part of the social marketing partnership which received a runner up prize at the Scottish Health Awards in 2008.

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This Community Health Initiative has been working for the past four years alongside local people and agencies to develop an infrastructure which promotes local health improvement activities in the area of Cambuslang and Rutherglen.

**Aim:** The Community Health Initiative (CHI) aims to provide local people with opportunities to take an active part in ensuring their own, their family’s and their community’s health and well-being.

**Design:** The Cambuslang and Rutherglen Community Health Initiative started in August 2004 as the result of a merger between the Cambuslang and Rutherglen Health and Food Project and the Cambuslang and Rutherglen Healthy Living Initiative.

For the past 3 years the CHI has been working alongside local people and agencies to improve health and well-being in the area and to work towards a healthier and happier culture in Cambuslang and Rutherglen.

The areas of work the initiative undertakes are based on needs that have been identified through extensive work with local communities and other stakeholders. CHI seeks to complement and add to existing local strategies and services. They work in partnership with local people, existing community, voluntary and statutory organisations to develop an infrastructure which promotes local health improvement activities and enables people and communities to plan ahead together.

A range of activities and services are delivered within the following themes: Volunteering; Communication, Information and Dialogue; Fitness and Exercise; Diet and Healthy Eating; Substance Misuse; Mental and Emotional Health and Well-Being. The initiative thus seeks to improve health in its widest sense. However, two of its major themes are Diet and Nutrition and Fitness and Exercise. These two themes are of particular importance in the struggle to tackle obesity. Listed below are some examples of the programmes and services that CHI operates in this area.

**Weaning Workshops;** Programme of workshops designed to inform and raise awareness of the benefits of weaning babies with home made food.
**Kids Food Handling**; Course designed by CHI targeted at upper school primary children. The basics of food hygiene, preparations, health & safety and presentation are taught in order for the groups to run their own healthy tuck shop within their school.

**Healthy Mums**; Programme designed to supply pregnant women with free fruit and vegetables from a local fruit barra for the duration of their pregnancy from 12 weeks to birth. The programme has now rolled out into a wider programme, supporting mothers to access a range of support and activities such as stress management, first aid and alternative keep fit.

**Junior Jog**; Junior jog is offered to all groups in the local area to come together to train and gain confidence in taking part in groups running in the local area. The aim of the group is to inform and raise awareness of alternative fitness options.

**Jogging/Walking Groups**; CHI support local jogging/walking groups and offer training and support to the local community to become leaders and participants. The aim of the groups is to bring together local communities to participate in safe walking in order to raise fitness levels.

**Health Issues in the Community**; A course delivered in the local area to tackle various health issues in the community using a community development approach. Topics covered include inequality, discrimination and prejudice.

**Fruit Family Game**; The fruit game was designed specifically for pre 5s. The purpose of the game is to encourage children to eat a variety of fruit and vegetables with no cost to the nurseries.

**Gardening Project**; We support local schools and communities to plan, implement and maintain gardens which in turn harvest fruit, vegetables and flowers to be either distributed or sold in the local area. The projects also offer volunteer and training opportunities for parents and local people.

**Camglen 5K**; The first local community fun run will take place in May 2009. This is to encourage the community to come together and become involved in walking, jogging, running or generally participating in community events. If successful, this will become a regular annual event.

These actions were set up aiming to have the following outcomes: People have increased access to information; People have access to healthier choices and make use of them; There are structures and networks that promote dialogue and information exchange in and between local people, community groups and local and national organisations; There are a range of activities which support and ensure local involvement; People are more involved, more skilled, more confident and less stigmatized; Community groups have ownership of activities in order to support individual and community well-being, contributing to the regeneration of the local area; Mainstream services are more responsive to the needs and wishes of local people.

**Support:** The Initiative has support and commitment from a range of funders and is seeking to continue these relationships and develop relationships with new funders in the future. During the first 5 years over £2 million of funding was brought into the area.

**Trigger:** Cambuslang and Rutherglen Community Health Initiative (CHI) was formed as a result of a merger between Cambuslang and Rutherglen Healthy Living Initiative (HLI), formed in 2002, and Cambuslang Health and Food Project (CHAF), established in 1997. The two organisations and their funders agreed that a newly merged organisation would have greater capacity to improve community health, and in August 2004 they became Cambuslang and Rutherglen Community Health Initiative (CHI).

**Targeted Communities:** Cambuslang and Rutherglen have a combined population of over 57,000. Falling within South Lanarkshire Council and NHS Greater Glasgow & Clyde areas, it is one of four localities within the South Lanarkshire Community Health Partnership. Poverty and inequality are apparent throughout the area. According to the SIMD (2006) 56 datazones in South
Lanarkshire fall into the worst 15% in Scotland: 21 of these datazones are in Cambuslang and Rutherglen.

There are a higher number of people in receipt of income support, disability living and housing benefits in this area than in wider South Lanarkshire. There is also a higher rate of people deprived of employment than the national average; with 23% of children living in households where no adults work. The impact of these statistics is reflected in South Lanarkshire health indicators. They evidence that there are comparatively high numbers of people living with limiting long term illness in Cambuslang & Rutherglen, incidences of cancer and coronary heart disease are significantly higher than the national average, as are the numbers of hospital admissions related to alcohol and drug misuse. The CHI is responsive to the changing needs of our communities. Local people have told the Initiative what they think would help their community; highlighting the reasons they believe people experience poor physical and mental health.

**Evaluation:** An interim Evaluation was carried out over the period of April 2005 until March 2007. The purpose of this interim evaluation was to examine how effectively the CHI was in meeting the outcomes set in 2005.

In short, it concludes that since 2005, the CHI has made excellent progress in achieving its outcomes. This was evidenced through the number of people using CHI services and testifying to the difference they make to their lives. It was corroborated by evidence from local practitioners in a wide range of services in both the statutory and voluntary sectors, who were very appreciative of the work of the CHI and noticed the impact it has made on the area.

The CHI has worked strenuously to involve local people in every aspect of its work and to be clearly seen as responsive to local need. At the same time it has forged strong partnerships with other agencies working in the area and its approach has made a clear impact on mainstream services.

However there is always room for improvement. During the course of gathering and analysing the information the team discovered several areas of work they were keen to address and improve into the future.

- The CHI recognises that it needs to improve its profile in the community. Volunteers, board members and staff themselves feel that organisation is still unknown to too many local people. The radio and media projects are attempting to address this issue and it is recommended that the focus on this area of work continues.
The board consists of local people and the FMR evaluation found that the CHI is “very much community driven”. It is recommended that the CHI maintains this track record and keeps striving to involve more people from the community at board level. Younger people, despite being a key focus of the work of the CHI, are not represented on the board.

Local ownership of groups and activities happens over time and with the right support. It is recommended that the CHI continues to focus on encouraging this over the next year and into the future.

It is recommended that younger people are more involved, not only at board level, but also in accessing and delivering services.

The evidence shows that there are more healthy choices available now in Cambuslang and Rutherglen than there were in 2005, but it is recommended that the CHI undertakes some research over the next year to find out both whether they think that there are more healthy choices available and also whether they think that services are more responsive to local need than they were.

More evidence is needed to show whether local people are more involved in strategic and working groups. It is recommended that the CHI gathers some data to show if this is happening.

Volunteering is proving to be a successful way to involve people and there is evidence to suggest that it is also successful in aiding people to move on. It is recommended that opportunities for volunteering are expanded and that ways of measuring the impact of people’s journeys are investigated and implemented.

The mental health and emotional well-being theme uses scales to assess the difference its interventions make to the people who make use of them. It is recommended that similar scales are used in other areas of CHI work so that an overall picture of changes for individuals can be built up.

Story gathering provides excellent case studies about individual’s experiences and progressions through their involvement with the CHI. It is recommended that the CHI increase the number of stories gathered and involve more focussed questions that are linked to outcomes.

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Healthy Valleys is a community led health improvement initiative located in the rural area of South Lanarkshire. The aim of Healthy Valleys is to reduce health inequalities by promoting positive lifestyle change amongst those most in need of additional support. Through its many programmes and projects the Initiative engages with disadvantaged children and families and the methodology deployed are underpinned by the Social Model of Health.

**Aim:** Healthy Valleys aims to:

- **Tackle health inequalities:** Healthy Valleys is committed to providing an integrated programme of services which tackle the wider determinants of health and ameliorate deprivation;
- **Address local health needs:** Healthy Valleys endeavours to address the health needs of local residents in a holistic fashion. This involves assessing need in a broad fashion and extending a range of healthcare options to clients in order that all of their needs are addressed;
- **Promote Community Involvement:** Healthy Valleys continually looks for new and innovative means to increase community involvement in the planning, development, delivery and evaluation of community health services;
- **Work in Partnership:** Healthy Valleys continues to work with mainstream services, private, voluntary and community sector agencies in pursuit of its organisational objectives;
- **Offer Additionality and strive for Sustainability:** Healthy Valleys endeavours to deliver services that respond to unmet demand and which are sustainable over the long term.

**Design:** Healthy Valleys is a voluntary organisation and registered charity, established in 1999. Through its many programmes and projects the Initiative engages with disadvantaged children and families and the methodology deployed is underpinned by the Social Model of Health. Partnership working is essential to address the wider determinants of health and well being. Healthy Valleys is embedded in community development and is governed by a Board of Volunteer Directors, 8 of who are local people and the other two from the local authority and NHS Lanarkshire. Due to the success of Healthy Valleys the organisation now covers the whole of rural South Lanarkshire.

Healthy Valleys adopts a community development approach to health improvement; participation, engagement, involvement and empowerment are essential ingredients to community led health improvement. With this approach, it aims to tackle four main health themes:

- Positive Mental Health and Wellbeing
- Coronary Heart Disease and Obesity
- Sexual Health
- Addictions

The Rural Access to Recreation and Education Project (RARE) is an amalgamation of two successful programmes namely the Combating Obesity Programme (COP) and the Get Active Programme. The Combating Obesity Programme is a variety of healthy eating courses, namely ‘Healthy Weaning Initiative’ for parents with new born babies, ‘Ready, Steady get Cooking’ (targets primary aged children aged between 11 and 12 years, and ‘Feeding the Family’ which involves parents/guardians of vulnerable families.

The success of the COP is mainly due to the ‘hands on’ approach to nutrition. Participants learn how to cook healthy meals using fresh ingredients and try new foods. The COP is delivered by locally trained volunteers.
Adding to this is the Get Active Programme which offers a range of physical activity opportunities for people to improve their physical well being, this ranges from armchair aerobics to salsa dancing.

**Support:** Healthy Valleys is funded by the BiG Lottery (previously known as New Opportunities Fund, (NOF)), South Lanarkshire Council & NHS Lanarkshire. Funding was initially granted to develop programmes in eight villages within the Douglas & Nethan Valley areas, the villages are former coalmining communities.

**Trigger:** Healthy Valleys was established in 1999 with the coming together of a steering group of representatives from the community, voluntary and public sector agencies to consider the 1996 ‘Lanarkshire Health and Lifestyle Survey’. This survey indicated a number of serious health related issues affecting the Douglas and Nethan Valley areas, among them a higher than average morbidity from coronary heart disease, suicide, homicide and accidents.

The steering group led an initial community consultation workshop, following on from which, and from the interest shown in improving access to enhanced and additional health care opportunities in the local area. The concept emerged to create a Healthy Living Community (HLC) and a planning group was formed to take forward ideas from the local community and to submit a funding application to the NOF.

**Targeted Communities:** Healthy Valleys works with communities and facilitates new opportunities for people who would not readily access mainstream service provision. Through consultation with rural communities gaps in service provision were identified and an action planned developed to fill the opportunity gap. Involving local people at the outset ensured that communities were on board and supported the initiative. To ensure the most vulnerable people are reached Healthy Valleys works in partnership with a variety of statutory and non statutory agencies. For example, Social Work, (children and families), Community Health Partnership and Locality, Employability agencies, Housing Services, the Council’s Community Regeneration team and such like.

**Evaluation:** Healthy Valleys is continually evaluating and reviewing services delivery via a number of methods including written evaluation completed by participants, focus groups, case studies and follow up telephone calls. Strathclyde University completed an evaluation in 2007 which can be seen online. Furthermore, a database has been developed which allows the programme to track progress and development of every participant.
From the beginning, the participants are required to complete a health questionnaire to establish a baseline of information which is then followed up by an interim questionnaire in order to measure impact. In effect, the physical and mental health are monitored and well-being of the individual throughout contact with Healthy Valleys.

The outcomes of evaluation, related to the RARE project were:

- Increased/improved fitness for all ages
- Improved self confidence and self esteem
- Increased levels of community participation
- Increased service provision for children, young people and adults
- Participants are more informed of what to eat
- Participants more able to prepare healthy meals for themselves and their families
- Improved knowledge of preparing food safely
- Increased knowledge of fats, salt intake and sugars
- Less feeling of isolation
- Learnt new skills & feel less stressed or anxious

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This is a multi disciplinary project, providing high quality support for young people and their families, to ensure that they make most of the educational opportunities on offer.

**Aim:** The project aims to:

- provide high quality support for young people and their families
- encourage a positive attitude to learning which will help young people to make the most of their opportunities in life
- be active in the promotion of a healthy lifestyle through the curriculum, the whole school and the wider community
- work with parents more closely to provide opportunities for lifelong learning and support before, during and beyond the school day

**Design:** New Community Schools was a Scottish Office initiative and was launched in 1998. The first pilot started in 1999 with two subsequent pilot phases in 2000 and 2001. Within this Authority there was a phase I pilot and a phase III pilot these were merged in 2006 to form one project, however it was not until 2008 that the staff were given permanent contracts as up until that time the project had been funded on a short term basis. Originally the pilot projects were based on the American concept of the full service school and was a new initiative in Scotland.

The project is a multi disciplinary one with the team made up of Health Development Workers, Home/School Link Workers, Social Workers and Attendance Officers. The team is managed by an Integration Manager and work in all primary and secondary schools within the authority. The programme is also involved in some Special Needs Schools and in some Early Years Establishments.

The staff members work with pupils, their families and school staff to ensure that the child or young person makes the most of the educational opportunities on offer. This can involve supporting the young person, child or family through a short or long term crisis, acting as an advocate in discussions with the school, health professionals, social work and Children’s Panels. The team work closely with a wide range of statutory and voluntary partner agencies. Programmes are delivered both in school and on an after school basis. They also organise a range of holiday provision as well as specific programmes for young people moving from primary to secondary school and who have been identified as likely to face significant challenges when making this move.

Some programmes that have been set up and their benefits to those the project has targeted are:

**Breakfast Club provision** in fifteen primary schools giving the children a healthy nutritious start to the day. Head teachers have noted improved performance, better behaviour and more settled and learning ready children. The children enjoy the company of their peers and friendly helpful staff underlining the social aspect of food. The children are king and a provision of the highest quality is made available to them.

**Healthy cooking classes** for primary children (Cookery Bookery) enabling them to learn to cook basic healthy meals which they share with the other children. They also make enough that they can take some home for the evening meal and during the week they have to try out a similar recipe and say how they managed the next week.

**Cookery Classes** for young people who are Looked After and Accommodated in order that when they leave care they will be able to cook healthy meals also similar classes for those leaving school to go to College.
Parent Cookery Classes to give parents basic cooking skills to help them prepare healthier meals for their families.

Tasting sessions in schools for children from nursery to P7 to enable them to taste and try different foods.

Consequences a programme about the social, economic, emotional and educational disadvantages of becoming pregnant whilst still at school

Baby sitting programme giving a first step in basic child care

Programmes of Emotional Literacy and Emotional Intelligence to help children and young people cope better with their feeling and to understand the implications of their actions

Programmes on bereavement and loss to help children and young people cope with separation due to death, divorce or prison.

Programmes of parenting to support parents to put in place appropriate boundaries and to have realistic expectations of their children and young people.

Out of school programmes in practical skills to support those young people who find it difficult to sustain a place in fulltime education.

Programmes of anger and behaviour management, self esteem and confidence building to support young people and children in becoming effective contributors, responsible citizens, successful learners and confident individuals

Steps to fitness targeting children and young people who are overweight and working with parents to improve their general health and fitness.

Support: Initially the funding for the programme was ring fenced and could only be used for the development of Community School provision and this was the case until 2008. The funding up until that time came in the form of grants from the Scottish Executive and latterly the Scottish Government. In 2008 all grant funding was amalgamated into the core education revenue budget for the Authority.

In setting up the project partnerships were forged with Social Work, Health, Community Learning and Development and schools.

Figure 49: Inverclyde Integrated Community School
Source: Inverclyde Integrated Community School

Trigger: The trigger for the project was the realisation by the then Scottish Office that, “for too long, too many children have been condemned to repeat the cycle of deprivation, educational underachievement and failure. Their life chances are reduced at an early stage. The disaffection with school which follows has been tolerated. The wider barriers to learning that can prevent children realising their true potential have not always been addressed in a properly co-ordinated
fashion. Access to the necessary support has not been available where and when it is needed./ New Community Schools will embody the fundamental principle that the potential of all children can be realised only by addressing their needs in the round – and that this requires an integrated approach by all those involved./ A range of services is necessary to assist children overcome the barriers to learning and positive development - family support, family learning and health improvement”.

**Targeted Communities:** In all phases of the pilot, provision was targeted at those areas where the challenges were/are greatest. Within Inverclyde the two pilot areas exhibited some of the highest indicators of social deprivation. Inverclyde as an area has some of the worst indices of multiple deprivations in Scotland. These related to health, housing, educational qualification and employment/unemployment. As the indicators were particularly high in the areas selected for the project there was little danger of overspill and the accessing of services by those in less deprived circumstances.

Although the programme is a universal service, they do target provision at those with greatest need and there is an appreciation by head teachers that referrals to the service or provision which are made should in the first instance be for the most at risk groups.

**Evaluation:** There has been a national evaluation of Community School Projects; ‘The Sum of Its Parts’ published in 2004. The findings of this evaluation were less than positive but in some views fairly inconclusive. Within their own project there have been a number of small in house evaluations and these have always been very positive. Also as each school is inspected, the programme’s contribution to the establishment is evaluated and to date these have highlighted a high quality of service targeted at the most needy children, young people and families and which improves the quality of life for those involved with the Integrated Community School Project.

The general view by those who are involved in this programme is that Integrated Community School offers an effective service. The proof of this can be seen in increased consumption of fruit and vegetables, children who are willing to eat a variety of food, children and young people who understand the need for a healthy diet and regular exercise. There is also recognition from those in the slight to moderately overweight category that minor changes in lifestyle can bring about significant health improvement.

However it has to be said that the programme is part of a much bigger health picture and there have been a range of other inputs by organisations other than Integrated Community School which will have contributed to these changes. The programme has only been involved in one piece of work in relation to obesity and that had limited success in changing attitudes and habits long term. In many instances the issue for the children, young people and families with whom the project works is not obesity but mal-nourishment.

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**DELTA Project**

The Delta Project is defined as a group of proposals, strategies and didactic materials aimed to the promotion of healthy eating habits and physical activity, in a broader context of education for health.

**Aim:** The project promotes healthy life styles among the population with more emphasis on healthy diet and physical activity. Its specific objectives are to promote community participation - especially in the education sector, nutrition industry, mass media, etc. - into the development of the strategies, and to promote the implication of the government institutions and NGO’s into the activities of the Project.

**Design:** From 1992, the General Directorate for Public Health of the Canary Islands Health Service has been developing the Program for the Promotion of Healthy Eating (PAS, “Promoción de Alimentación Saludable”).

Due to changes in the social scenarios until 2005 (e.g. increasing, and virtually universal, progression of the epidemic phenomenon of overweight, creation of the European and Spanish agencies for food safety, edition of the Green Paper of the European Communities Commission) among other reasons, made it advisable to realign the methodological proposals of the PAS, which then became the actual “Delta Project on Nutritional Education” that was formally presented on December 2005.

![Figure 50: Fiestas de Mayo 2006](Source: DELTA Project)

The Delta Project is defined as a group of proposals, strategies and didactic materials, and it establishes three principles for action:

1. It started as an integrating, not excluding, consensus proposal.
2. It is intended to reach first those who most need it.
3. It is based on a founded technical and scientific basis.
Support: The Project has been financed by the Government of the Canary Islands. Parties involved are the Regional Government of Education, Culture and Sports, City Councils, Sports Clubs, Industries from the nutrition sector, etc.

Trigger: The project was an initiative from the Regional Government.

Targeted Communities: The Project targets the general population, but makes an especial focus on vulnerable groups. However the interventions are for all.

Evaluation: The objectives of the health plan, the ministerial guidelines, the questionnaires about the activities carried out and the monitoring epidemiologic studies are evaluation indicators that are taken into account. Other indicators evaluate the impact, coverage and results. In addition to that, the Delta Project is developing a protocol to be applied in two municipalities for a period of three years, in order to evaluate the methodology and internal and external validity, with the participation of relevant academic authorities and well-known scientists.

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5. Overview of Responses

All the 71 projects described in this report aim to address and tackle the obesity problem across the gradient, with a specific focus on lower socio-economic groups. In order to achieve this there are, however, differences in methodologies, target groups reached, settings, scale and scope. The following chapter therefore lays out what common core approaches were used by the interventions described to reduce obesity, and which designs were implemented to specifically focus on the promotion of healthy nutrition or physical activity. It gives an overview of the responses, classifies the different elements that can be used and lays out possible innovative and promising approaches.

Target Group

Many of the practices described focus on the prevention of obesity and promotion of health equity among one or more specific target groups. The following groups can be identified that were targeted by the interventions described in this publication:

1. Children (and their families)
2. Ethnic minorities
3. Women / gender inequalities
4. Older people
5. People with a low educational background
6. People living in deprivation – rural areas
7. People living in deprivation – city districts
8. Additional groups (e.g. persons having debts)

Setting/Access to information

The following settings were used by the practices described to reach the target group and make them aware of the possibility to get involved and participate in the different health promoting activities:

1. Contacting directly
2. Low-threshold centres (e.g. healthy living centres, drop-in clinics)
3. Schools / youth centres
4. Media (e.g. leaflets, newspapers, add shells)
5. Multi langue, culture specific distribution materials
6. Medical authorities (e.g. pharmacies)

The following persons acted as intermediates:

1. Experts (e.g. dieticians, physiotherapists)
2. Role models /peer educators (e.g. professional football players)
3. Intercultural mediators (e.g. migrant chair person)

General Methodologies

Interestingly, all interventions described in this publication focus on the promotion of healthy lifestyle activities, and not on the prevention and reduction of unhealthy products or environments. This characteristic of the projects could therefore be seen as additional to addressing the structural determinants of social inequality.

The following methodologies described were used to develop health-promoting interventions. Most projects incorporate more than one of these methodologies.
**Provision of Information**

1. **Provide practical information and tips on healthy nutrition and/or (daily) physical activity** – e.g. what is the daily amount of fruit and vegetables a person should take, how many minutes a day should you be physically active and how can you prepare a healthy but cheap meal.
2. **Provide information in a fun and interactive way** – e.g. using games, workshops, tasting sessions etc.
3. **Provide opportunities for the target group to share information and discuss personal experiences** – e.g. give participants the possibility to reflect upon their own experiences, to discuss difficulties, and to promote dialogue and information exchange in and between individuals and groups.
4. **Enhance and improve the knowledge of the target group about the importance of an increased fitness in relation to medical conditions** – e.g. diabetes, cardiac health, metabolic syndromes etc. Put emphasis on the aspect that it will be a life-long benefit to improve your fitness.
5. **Develop a more positive attitude towards the consumption of fruit and vegetables and physical activities** – e.g. healthy nutrition doesn’t have to be expensive and doesn’t have to require a lot of time to prepare.
6. **Gain insight into relation between overweight, nutrition and physical activity and the role of social pressure, emotion and cultural habits**

**Empowerment and participation of the target group**

1. **Empowerment of the target group** - Increase their sense of control, self-esteem and self-confidence and make them recognise their ability and capacity to improve their own personal circumstances and that of their relatives.
2. **Improve social cohesion** – Encourage the target group to join group activities (e.g. eat jointly together) and to become more actively involved in the community. Establish social networks to ease social isolation and facilitate networking among community groups.
3. **Involve participants in the whole process of the intervention** – let the target group contribute to the development and running of the project and encourage their participation and involvement. E.g. train (dedicated) participants to become multipliers/co-trainers.
4. **Provide health training and education or employment opportunities**

**Access and availability**

1. **Improve access to services** – e.g. promote locally grown products, improve the supply of healthy food to people or create healthy playgrounds in the neighbourhood of the targeted communities.
2. **Improve availability of healthy food and physical activity** – provide a wide range of food and physical activity events that the target group can choose from. E.g. encourage local retailers to promote healthy, low-cost food options and encourage schools to organise sport events.
3. **Organise theme based consults/activities** – e.g. mental health, healthy nutrition, fitness and exercise, well being and emotional health.

**Methodologies – Nutrition** The following methodologies were used when the aim of the interventions was to promote and increase in consumption of healthy food.

1. **Provide learning/training opportunities on gardening skills and techniques** – Enhance knowledge and skills in relation to fruit and vegetable growing (gardening processes). Learning inside the garden will hopefully be transferred to participants’ own homes.
2. **Provide nutritional education and enhance the participants cooking and preparation skills of healthy nutrition** – e.g. providing opportunities to ‘cook and try’ (cookery clubs, workshops, tasting sessions etc.)
3. **Emphasise on the financial aspect** – healthy nutrition doesn’t have to be expensive (e.g. provide household budgeting skills, providing the target group with a menu for a limited budget for a week)
4. **Develop purchasing activities** – e.g. organise supermarket tours, enhance the knowledge of the target group on how to read food labels.

**Methodologies – Physical activity** The following methodologies were used when the aim of the interventions was specifically to promote and increase physical activity among the target group.

1. **Involve the parents of participating (obese) children** - enhance their knowledge of the importance of increasing their children’s physical activity and explain how they can support their kids to improve their fitness. Show them the importance of the role they can play.

2. **Measure indicators of obesity to motivate the target group to change their lifestyle** – e.g. blood pressure, cholesterol levels, blood sugar monitoring, height/weight assessments.

3. **Motivate the target group to continue with physical activities by rewarding them** – e.g. using stamps each time they finished a specific task, give participants a diploma at the end.

4. **Motivate the target group by continuously monitoring and evaluating their performances** – e.g. fitness test/ follow up system/ database/blueprint the participants functioning. Stimulate them in a structured way.

5. **Let the participants make a commitment to participate** – set goals for change. Let them work towards a certain point/goal.
6. Conclusions and Discussion

It is known that obesity prevention strategies are mainly set up to either encourage individuals to modify their lifestyle, to modify the obesogenic environment, or to develop legislative changes such as the implementation of policies \[65\]. However, to date it is unclear how often such approaches take health equity into account as well and what strategies are required when addressing obesity in relation to health inequalities. This report has tried to address these questions by collecting relevant information and has concluded the following.

It seems that the implementation of projects at local level plays an important role when the goal is to target disadvantaged communities. This result is confirmed by previous studies, as they have shown that lower socio-economic groups are less likely to respond to programmes implemented at national level. In addition, mass media and health education campaigns have higher dropout rates among disadvantaged communities compared to high socio-economic classes \[9, 66, 67\].

Community-based health promotion efforts are one of the strategies that can be set up to address health issues among groups at local level. These approaches show the importance of involving vulnerable communities during the development, implementation and evaluation of a project. By approaching and engaging vulnerable groups directly, they are more susceptible and willing to change their behaviour towards a healthier one.

The information collected further identified the importance of the development of partnerships when preventing obesity. Not all parties involved necessarily need to be active within the health sector; external stakeholders are often crucial, including economic operators. Many practices described used such a cross-sectoral approach, and have proven to be successful as a behavioural change was often identified among the target group. It is thus important to address the obesity problem from different sectors and angles \[68\].

Even though 71 examples of projects were included in this report, only a few of them have been properly evaluated. Controlled intervention programmes are needed to examine their effect on different socio-economic groups and their effect on a long term basis. Also, European level comparisons of the impact of support of local health services on the prevention of obesity among communities from deprived areas would bring added value. They have improved the processes of care, but a definite proof of improved disease outcomes is still lacking \[9\].

Finally, as most of the prevention projects targeting communities are implemented at local level, it is likely that they will not be noticed at national level. Monitoring and accessibility of data and information of local initiatives is a precondition to scaling up and horizontal transferability. By monitoring the initiatives via - for instance - umbrella organisations (a good example is the Community Food and Health organisation in Scotland), evidence, experience and knowledge can be shared and exchanged within and between countries at a European level.
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